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THE

DUBLIN HOSPITAL GAZETTE;

A Journal

FOR THE CULTIVATION AND IMPROVEMENT OF PRACTICAL MEDICINE AND SURGERY.

PUBLISHED ON THE 1ST AND 15TH OF EACH MONTH.

VOL. II.—1855.

DUBLIN:
PUBLISHED BY W. B. KELLY, 8, GRAFTON-STREET.
LONDON: S. HIGHLEY, 32, FLEET-STREET.
EDINBURGH: MACLACHLAN AND STEWART.
1856.

BOSTON MEDICAL
OCT 25 1897
LIBRARY

CATALOGUED
OCT 25 1897
E. H. B.

DUBLIN:
PRINTED BY J. M. O'TOOLE,
13, HAWKIN'S-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.

SENT FREE BY POST.

Annual Subscription, 10s.; Half-yearly, 5s., payable in Advance.

BOSTON MEDICAL LIBRARY
OCT 26 1897

Dublin Hospital Gazette.

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No. 1.—VOL. II. FEBRUARY 1, 1855. PRICE 5D.

MEATH HOSPITAL.

Case of Diffused Abdominal Aneurism.

BY WM. STOKES, M.D.,

ONE OF THE PHYSICIANS TO THE HOSPITAL.

MICHAEL MALONE, æt. 30, was admitted on the 6th of December, 1854. His occupation is that of a corn-porter. His habits had been temperate; and up to about nine months ago his health remained unimpaired.

At that time he first perceived a sense of weakness in the back, attended by a dull pain in the lumbar region; but these sensations did not prevent him following his occupation. In about six weeks, however, he became liable to paroxysms of pain, which he referred to the abdomen. This pain he described as a burning pain, aggravated at night, and attended with flatulence and constipation. During the paroxysm of the abdominal pain he always found relief from pressure.

He continued in this state, with but little change, until a short time previous to his admission, when the symptoms of abdominal pain, flatulence, and constipation became more troublesome.

On admission he complained principally of constipation, and of weakness of the back and lower extremities. His general appearance was not that of a person labouring under any serious visceral disease. Neither the abdomen nor the loins presented anything remarkable; and it was only observed that the large intestines were to a certain degree distended with air. He was always relieved by the use of aperients.

On the 14th of December a new set of symptoms suddenly set in. On turning in his bed from the left to the right side he felt a sensation as if something had given way within him; he described it as a crack or tear; this was immediately followed by a burning pain extending from the left lumbar region towards the umbilicus, and affecting the left thigh as far as the knee. He also felt immediately and for the first time a peculiar throbbing at the left side of the abdomen. At the hour of visit next morning, a remarkable change was perceptible in the appearance of the patient; his countenance was sunken and pale, and he looked as a man about to die; he lay on his back with the left thigh drawn up, any attempt to extend it giving extreme suffering.

A large pulsating tumour was found occupying the region between the false ribs and crest of the ilium. The pulsation was single, but so strong and extensive that it could be perceived at a considerable distance from the bed; in fact it occupied the whole left hypochondriac and lumbar regions. This pulsation was of a violent heaving character, and was attended with a loud hoarse but single bellows murmur, most distinct at a point about an inch to the left of the umbilicus, but sufficiently evident over every part of the tumour. In the upper portion, and more posteriorly, the hand detected a deep-seated thrill or fremitus, occupying a space about three square inches. The murmur could be heard along the spine, and also existed in the carotids. The action of the heart had become excited, but at this time its sounds were unattended by murmur. The left femoral artery continued to pulsate, and no difference could be detected between its action and that of the opposite vessel.

From this time to the period of his death no important change took place; the tumour steadily increased in size, but became much firmer, especially in its superior portion. After a few days a second tumour appeared, a little to the left of the mesian line, and about two inches below the ensiform cartilage. It was not possible to say whether this new tumour was a process or portion of the great lumbar tumour, or whether it was a new deposit of blood. It pulsated, and the sounds were double; but this latter character seemed to result from its pressure on the diaphragm and heart.

In the course of a week from the occurrence of the rupture, the heart's action became more feeble; the sounds were more obscure and muffled, and ultimately a systolic bellows murmur was developed in the heart. The patient's sufferings were extreme, from the feeling of weight, pain, and tension in the side, and from the burning pain in the thigh; his bowels were moved with great difficulty, and for some time he passed so little urine that it was imagined that he was unable to empty his bladder.

The posterior and lateral portions of the vast tumour became œdematous, the breathing was oppressed, and after one or two days' continuance of a sero-sanguinolent expectoration, the patient died, but not with any new or sudden symptoms.

The dissection, which was performed under very disadvantageous circumstances, and at the residence of the patient, showed the existence of a vast tumour occupying the left side of the abdomen and the lumbar region. It extended from a little above Poupart's ligament to the thorax, and was bounded posteriorly by the muscular structure and in front by the peritoneum, which it had pushed before it; the kidney lay in front. There was no effusion of blood into the peritoneal sac, or between the folds of the mesentery. Not less than six pounds of coagulum and blood were contained in the tumour.

Owing to the hurry, and other circumstances of difficulty under which the dissection was performed, it was not ascertained from what point of the vessel the original aneurismal tumour had sprung. The aorta was, however, found to be healthy to the origin of the renal artery; and there is a great probability that the aneurism arose somewhere between this point and the bifurcation. A portion of what seemed to be the original sac was removed, which exhibited an opening into the large tumour of more than two inches in length.

The amount of fluid blood in the tumour, as compared with that of the coagulum, was small, and might be fairly estimated at about one-fourth of the entire contents.

In commenting on this case Dr. Stokes said, that although it was to be considered as an imperfect case, it still went to establish some valuable points in the history of abdominal aneurisms. Of these the most important was, that the tumour formed by the diffused portion of the aneurism might present a strong pulsation. He observed, that the formation of bloody tumours, secondary to the original false aneurism of the abdominal aorta, and having their seat in the cellular connexions of the peritoneum with the muscular masses which form the lateral and posterior parietes of the abdomen, was a circumstance long known to the pathological anatomist. Such cases have been mistaken for lumbar abscess; and the existence of a pulsation in these tumours had been denied by some authors. In some cases, however, which had occurred in the Meath Hospital, and which he had published, a feeble but decided pulsation had been detected in these tumours. It was not sufficiently strong to cause a visible heaving of the whole mass, but could be ascertained by placing the flat of the hand upon the tumour. The case established two points that were new in the history of this lesion: one, that the pulsation of such tumours might be vehement and extended, and the other, that it might be accompanied by a thrill analogous to that which occurs in varicose aneurism. It was a remarkable circumstance, too, that the thrill disappeared after the lapse of a few days, while the diastolic pulsation continued. This pulsation, too, it was to be remarked, although always visible even at a distance, had not the violence which attends the throbbing of an ordinary false aneurism. It was a manifest strong and extended pulsation, but still not so vehement as that which would attend an aneurism of great size, in which a secondary rupture causing diffusion had not taken place.

The existence of an abdominal aneurism in this case was not recognized until the period of the diffusion of the tumour; yet it is clear, that had the symptoms been sufficiently considered, the nature of the disease ought, at least, to have been suspected. Dr. Stokes observed, that owing to the great pressure of the acute cases, he had not directed much attention to the investigation of the symptoms during the few days previous to the rupture of the sac. And it was to be remarked, that the symptoms, although they were, doubtless, sufficient to lead to a suspicion of the nature of the disease, yet had not those decided characters which had, in several instances, led to the diagnosis of abdominal aneurism, quite independent of its physical phenomena. These symptoms, as diagnostic of the disease in question, were first established by the publication of Dr. Beatty's case of abdominal aneurism in the fifth volume of the Dublin Hospital Reports. And it is probable, that the fact of the original lesion of the vessel being seated very low down, was the cause, if not of their absence, at least of their modification in the present instance.

In conclusion, Dr. Stokes observed that the case, though deficient and imperfect, not only as to the non-recognition of the nature of the malady previous to the rupture of the sac; and again, the non-determination of the exact point in the vessel where the original perforation had taken place; yet, it established that a diffused abdominal aneurism might have not only a very strong and visible pulsation, but that the pulsation might for a time be attended with fremitus. We may then enumerate three forms of diffused abdominal aneurism.

1. Formation of one or more lumbar tumours gradually, and as it were, silently, in cases where the original disease had been recognized. These tumours present a feeble diastolic pulsation, while the force of the pulsations of the original tumour becomes diminished.

2. Formation of a large tumour within the abdomen, with a localized thrill. In a case of this kind published by Dr. Stokes, the secondary opening was between the folds of the meso-colon.

3. Formation in a sudden manner, of a tumour, rapidly increasing, and seated between the muscular structures and peritoneum, attended with strong extended and visible pulsation, accompanied at a certain point with a distinct thrill.

In this case the remedial or palliative measures employed were the use of opiates in full doses, the use of the chloroform liniment, from which the patient always derived great comfort, and lastly, the passing the electro-magnetic current along the surface of the tumour. This was done by Dr. Moore on three occasions, and on the first its use was followed by such alleviation of the pain along the thigh, that the patient was enabled to extend the limb immediately afterwards.

ST. VINCENT'S HOSPITAL.

DR. O'FERRALL'S CLINICAL WARDS.

Mammary Tumour; its Characters; Hæmorrhage; Removal by Operation; its Anatomy; Micrology.

Mrs. L——, thirty-eight years of age, mother of seven children, the last only eighteen months ago, was admitted on account of a tumour of the left breast. When first discovered, five months ago, it was, according to her statement, about the size of a pea. It was then colourless, free from pain or inconvenience of any kind. About three months ago she began to suffer shooting pains in the tumour, and about the same time, or soon afterward, it assumed a purple colour. She had lost flesh during the six previous months, but was not conscious of any other unfavourable alteration in her health. Menstruation continues regular to the present time.

The situation of the tumour was over the sternal extremity of the left mamma; about half an inch of healthy looking integument intervened between the margin of its base and the margin of the areola of the nipple. The nipple was free, and of its natural size and length. The colour of the tumour was deep purple, its surface smooth and uniform, and it was elastic to the touch; its projection was about an inch and a quarter, its figure nearly hemispherical, but a little broader at the base, which gave to it a slightly conoid shape. It resided, evidently, in the sternal extremity of the mammary gland, and when both were raised up and drawn forward, a considerable degree of mobility seemed to exist. When the arm was kept strongly separated from the side the growth still seemed to be moveable, and was clearly so, as regarded the parietes of the chest, whatever might be its relation to the pectoral muscle. There was no morbid growth in the axilla.

A few days after admission, a perforation took place in the most prominent part of the surface of the tumour; from this point a hæmorrhage occurred which created some alarm in the mind of the patient, and made her anxious for operation.

December 22nd.—Two long incisions were made to include the mammary gland and a portion of healthy integument beyond the base of the tumour. The separation of the gland was effected with facility, until it reached that part corresponding to the morbid growth, and here a certain degree of attachment to the pectoral muscle appeared to exist. A thin layer of the muscle was accordingly removed with the tumour, and the operation thus concluded. The portion of muscle, on examination, appeared perfectly healthy.

Anatomical Characters.—A section carried through the mamma, the nipple, and the tumour, presented the following appearances:—

A thin surface of the tumour under the integument was of a deep purple colour. Nearer to the base, and not far from the pectoral muscle, was an irregular cavity, containing what was manifestly an apoplectic clot; and between those two points the tumour was of a yellowish, brain-like appearance, and yielded, on very slight pressure, a thick creamy fluid. The morbid mass was surrounded by a cellular capsule which appeared to completely insulate its structure. Between the capsule and the nipple a section gave issue to a thin creamy liquid, which escaped from visible tubes. This liquid, although in some degree resembling what issued from the tumour, differed from it, having a thinner consistence and paler colour. The structure of the nipple was perfectly soft and healthy, as was also that of the mammary gland on its axillary side.

Micrology.—The following examination was kindly made by Dr. Aldridge:—The thick creamy liquid from the tumour was found to contain cells of various kinds and numerous oil drops. Some of the cells were large, oval or round, and thickly dotted all over without any perceptible nucleus; others contained distinct nuclei; whilst, in some few instances, the large spherical well-defined cells had no dots (nucleoli) except in the nucleus. The great majority of the cells were small, about the size of pus globules, and so exactly resembled the nuclei of the larger ones, that one could hardly avoid regarding them, either as escaped nuclei or as undeveloped cells. Besides the cells and nuclei, there were numerous exudation cells and masses distinguishable by their mulberry-like appearance, and some caudate cells and spindle-shaped bodies, probably incipient fibres.

The liquid which issued from the divided lactiferous tubes between the tumour and the nipple was found to present—1st, numerous oil drops; 2nd, pavement epithelium; 3rd, cylindrical epithelium frequently ciliated; 4th, free ciliæ; 5th, granular matter.

JERVIS-STREET HOSPITAL.

A Case of Luxation of the Femur Backwards, with brief Remarks.

BY JAMES S. HUGHES, M.D., F.R.C.S.I.,

EXAMINER IN SURGERY IN THE QUEEN'S UNIVERSITY IN IRELAND.

Reported by MR. JOHN LUBE.

Thomas Butler, æt. 18, fat and muscular, a porter by trade, was admitted into Jervis-street Hospital on the 27th March, 1854, under the care of Mr. Hughes.

History of the Case.—At half-past eight o'clock this morning, the patient was driving a dray, seated on a crate, which being unequally loaded suddenly toppled over, when he was precipitated to the ground with great violence; he fell on his left side, but has no recollection of the precise position in which his leg was placed in the act of falling, neither was he conscious of anything having given way at the time of the accident, but he experienced excruciating pain in the left hip immediately after the fall. On the patient being placed in bed in the recumbent position, the following appearances presented themselves:—The left lower extremity was a little more than half an inch shorter, by measurement, than the right one; the left knee, which was slightly flexed, was a little in advance of the right one; the left foot, which was somewhat apart from the right one, was nearly straight, with the slightest possible inclination to eversion. A remarkable alteration in the contour of the left thigh was perceptible, owing to the absence of the natural prominence of the trochanter of that side, and to the thigh being increased in depth in its antero-posterior direction. The trochanter of the injured side could readily be detected behind its normal position, but the head of the bone could not be distinctly felt. The thigh admitted of flexion on the pelvis to a considerable extent, but it could not be fully extended; the foot admitted of slight rotation both inwards and outwards, but these movements were attended with excruciating pain. On having the patient supported in a standing position on the sound limb, the left great-toe reached the floor, the heel of the same side being elevated: in this position the patient could not hold himself erect, in consequence of which the lumbar vertebræ presented an arched or incurvated appearance. After making a careful examination of the case, Mr. Hughes pronounced it to be an example of luxation of the femur backwards, in which opinion he was joined by Mr. Stapleton, his colleague on duty at the time. The following measures were then immediately taken for the reduction of the luxation:—The patient having been placed on his right side on a firm bed in the operation theatre, Mr. L'Estrange's pulleys were adjusted, the patient having next been brought fully under the anæsthetic influence of chloroform; extension was commenced in the direction downwards and forwards across the opposite thigh; Mr. Stapleton taking charge of the limb below, whilst Mr. Hughes lifted the head of the bone out of its new position by means of a towel thrown round the upper part of the patient's thigh, and by steadily increased extension, the head of the bone was, in the course of a few minutes, brought clear of the margin of the acetabulum; when, on Mr. Stapleton rotating the limb outwards, the pulleys having at the same time been suddenly let go by Mr. L'Estrange's "Spring Detacher," the head of the bone slipped into the acetabulum, reduction being accompanied by a loud noise, and sensible chuck, after which all deformity was found to have disappeared. The patient was kept in the recumbent position for a few days, at the expiration of which he left the hospital quite well.

Remarks.—The foregoing case of luxation of the femur backwards presents some features of practical interest, which may be thus briefly enumerated.

Firstly. It proves that the position of the foot, with "the toe resting against the great toe of the other foot," which has been laid down by the majority of authors as one of the diagnostic signs of luxation of the femur backwards, is not *necessarily* present in that injury.

Secondly. It exhibits a symptom so much dwelt on by Mr. Syme, as diagnostic of luxation of the femur backwards, viz.:—An arched form of the lumbar vertebræ, "so long as the thigh is straight, or on a line with the patient's trunk," and which was most obvious in Butler's case, when the patient was supported in the standing position on his right leg, the left thigh being at the same time as far extended as the circumstances of the case would admit.

Thirdly. It points out the valuable assistance which the surgeon may derive from the full exhibition of chloroform by inhalation in the reduction of that luxation, which has been described by Sir Astley Cooper as "the most difficult both to detect and reduce."

STEEVENS' HOSPITAL.

Case of Idiopathic Diffuse Inflammation of the Subcutaneous Areolar Tissue of the anterior and lateral Parts of the Neck; extensive Sloughing of that Structure, and the superjacent Skin complicated with Laryngitis, Pneumonia, and Bronchitis; Death.

BY SAMUEL G. WILMOT, M.D.,

SURGEON TO THE HOSPITAL.

Robert Lamb, aged 37, a carpenter, presented himself at the hospital on the morning of Saturday the 9th of December, 1854, complaining of pain and stiffness in the front of the neck, of hoarseness and some cough. On examination, an erythematous redness was observed on the anterior part of the neck, and a good deal of diffused swelling, which ran upwards from the sternum to the angle of the jaw on each side. His pulse was quick, and his tongue foul.

He stated, that on Monday the 4th instant (five days previously), while at work, he was seized with pain behind the angle of the jaw on the left side, this gradually increased and became diffused over the same side of the neck. On the following Thursday, he, for the first time, perceived swelling and redness of the skin, and he then became almost unable to move his neck. He stated that he never had any rigors. He could not recollect having received a wound, scratch, or injury of any sort, but acknowledges that he has been very intemperate for many years, being accustomed to drink ardent spirits in excess.

Though the dangerous nature of the case was fully represented to the patient, he refused to come into hospital for two or three days.

Tuesday, 12th.—He has since been admitted into No. 7 Ward. The swelling has greatly increased, and the redness has become much deeper since Saturday last. The entire of the anterior part of the neck from the sternum upwards to the angle of the jaw on each side, and to a considerable distance laterally, is occupied by a diffused swelling, which is evidently produced by inflammation of the subcutaneous areolar tissue. The feel it yields is peculiar, it is not the feel of œdema, neither is it the brawny sensation conveyed by phlegmonous erysipelas in its first stage. The swelling is firmer along the trachea than elsewhere, and it runs as high as the os hyoides; some of the disease has also extended a short distance over the upper part of the sternum. The patient complains of soreness and difficulty in swallowing, and of dyspnœa, and he respires as if there were some œdema of the glottis; no condition of this sort, however, can be detected by the finger, but there is slight redness of the fauces. Respiration is quick, and mucous rales are audible over the back of the chest, but there is no appreciable dulness. A good deal of febrile disturbance is present, but it is not at all commensurable with the nature and extent of the local disease. Immediately above the sternum, between the tendons of the sterno-mastoid muscles the swelling was somewhat prominent, and the finger sank into it. It was thought that this might indicate some collection of pus in the neighbourhood, probably in the loose areolar tissue behind the upper bone of the sternum, accordingly an incision was made through this spot, exactly in the mesial line, being carried through the fascia. No pus appeared, but some serum drained away, and in a few hours the patient expressed himself as somewhat relieved by the incision.

Thursday, 14th.—To-day there is dulness over the posterior lobe of the right lung, and a fine crepitus is audible in the same situation; on the opposite side loud bronchial rales may be heard. The patient's respiration, however, is easier than it was, which he attributes to his having spat up a quantity of yellow frothy mucus. A small abscess formed in the mesial line over the cricoid cartilage; it yielded a crackling feel, and the skin belonging to it was quite thin, and of a deep dusky red hue; on laying it open a little thin yellow pus and a considerable amount of fœtid air escaped. On the next day the skin which had covered the abscess was perfectly dead, and on cutting it away the areolar tissue beneath was found in a slough. From this period the gangrene of the areolar tissue and skin steadily progressed. Three or four abscesses, similar to the first, formed in different places in succession; each contained only a small quantity of thin yellow pus, but a good deal of foul air; and in each instance the skin, after the abscess was opened, rapidly sloughed, disclosing the dead areolar tissue beneath. Accompanying these local changes there was a good deal of constitutional disturbance, but it was strikingly disproportioned to the extent and character of the former. At the end of a week from the appearance of the first abscess the skin covering the entire anterior part of the neck was completely destroyed, and a dry ash-coloured slough of areolar tissue lay stretched across. The patient now, for the first time, became perfectly prostrated, and slight delirium alternating with a semi-comatose state supervened.

December 24th.—The destruction of the skin and areolar tissue increased considerably within the last two days; it has extended downwards over the upper part of the sternum, and outwards along the clavicles to some extent. The case presents a frightful spectacle. The skin covering the whole of the anterior and part of the lateral regions of the neck, as well as that of the upper part of the chest has been swept away, and nothing is to be seen but an extensive ashy-coloured slough of areolar tissue occupying the space. The slough is quite dry, and in no place does it present the least appearance of separating.

December 25th.—The patient died to-day, having lived exactly nineteen days from the date he first perceived the redness and swelling.

Treatment.—The internal treatment adopted in this case consisted in the administration, at first, of calomel, quinine, and opium; subsequently of carbonate of ammonia in conjunction with the decoction of senera, also wine, porter, and brandy. The local treatment consisted in making punctures and incisions wherever such were indicated, and in the employment of the usual applications—poultices, warm dressing, balsam of Peru, &c.

Observations.—It is much to be regretted that all efforts to procure an autopsical examination in the above case proved unavailing; nevertheless it is, as it stands, full of interest and instruction. It affords an excellent example of diffuse gangrenous inflammation of the areolar tissue; and since it was of undoubted idiopathic origin, it is the more rare and interesting. The consecutive sloughing of the skin, which is an essential feature in this disease, is here well marked; the skin obviously perished not from any excess of action in itself, but as the result of the destruction of the subjacent areolar tissue, by which it lost at once its vital and its mechanical support. It is highly probable that the gangrenous action extended into the loose reticular tissue which runs along the anterior mediastinum and partly around the root of the lungs; for though there was no opportunity afforded of verifying this, analogy confirms the conjecture. The complication of the disease with bronchitis and laryngitis shows the sympathy which exists between the skin and mucous membranes, and teaches us that in all such cases we must look for mischief beyond the actual external signs. It is likely that in this, as in similar cases, the submucous areolar tissue of the larynx was infiltrated with a sero-purulent fluid. The co-existence of pneumonia is common in all forms of inflammation of an erysipelatous character. I have termed the disease in the present instance gangrenous inflammation of the areolar tissue, though the epithet may not be exactly correct, in order to distinguish it from the more ordinary form of "cellular inflammation," which consists in the infiltration of the tissue with pus, without any gangrene occurring, and which, from its probable connexion with "capillary phlebitis," is in general more rapidly fatal. The following case contrasts very remarkably with the preceding, particularly in point of duration:—

A large, powerful looking man was admitted into Steevens' Hospital two or three years since, with all the symptoms of low typhus fever, which it was stated had only appeared on the previous day. A slight erysipelatous blush, together with some diffused swelling of rather a firm feel, extended over the left shoulder, also to some extent on the chest and back on the same side. The intensity of the constitutional symptoms seemed hardly to be warranted by the apparent extent of the local disease. The patient died in thirty-six hours from the date of his admission. On making incisions into the diseased parts after death, the areolar tissue was found everywhere infiltrated with a milky sero-purulent fluid, and on raising the sternum, the reticular tissue in the anterior mediastinum presented a beautiful yellow appearance from being injected throughout with pus. The lungs were enormously congested, and the inferior lobe of the right lung exhibited the *post mortem* signs of pneumonia in its first stage.

TALBOT DISPENSARY.

Case of Sclerema, or a peculiar Induration of the Skin over a great Part of the Surface of the Body.

BY ROBERT M'DONNELL, M.B.T.C.D., F.R.C.S.I.

Mary Connell, a strong, robust-looking country girl, aged 28 years, appeared among the patients at the Talbot Dispensary, August 11th, 1854.

She complains of a hardness and rigidity of the skin over a great part of the body. Her appearance is peculiar. The skin of the face seems tightened and shining; there is a want of the power of expression in the countenance, the integument of which is so rigid as not to admit of the free movements of the brow and around the eyes and mouth, which are essential to an expressive countenance. She smiles or laughs with difficulty. As she says herself, her face feels stiff, as if it were coated with varnish or starch. The skin covering the neck, chest, shoulders, and arms, is in a similar hard and rigid condition: it feels not unlike the skin on a flitch of bacon. The mammæ are firm, and like brawn; the calves of the legs have a hardness like phlegmasia dolens. The abdomen and thighs are comparatively free from induration, with the exception of a patch the size of one's hand, above the right knee. The skin looks quite natural, except on the face, where it seems tense and shining, and browned, as if by exposure to the weather; it cannot be pinched up, nor even moved with freedom over the subcutaneous structures: this is most remarkable around the eyes, where the cellular tissue is in general lax. The peculiar rigidity seems to be seated in the subcutaneous cellular tissue, but does not depend on œdematous infiltration of it. There is no pitting upon pressure. The patient states that her general health has been and still is very good; pulse (which is not very readily distinguishable at the wrist through the indurated integument) 80; heart's sounds normal, and very distinctly audible; urine apparently normal, and *not* albuminous; no derangement of the menstrual functions. She complains of chilliness over the surface of the body, especially in the extremities; but, with this exception, she suffers from nothing more than the "*stiffness of her skin,*" and slight loss of flesh.

The complaint originated twelve months ago. It commenced in the neck and arms, and gradually spread to the other parts affected; for the last two months it has not become worse; the free motion of the joints is, to a slight extent, impaired; the wrists and ankles less stiff than the other joints. She does not suffer from globus hystericus, or other hysterical affections.

She was under treatment for more than a month, during which time she took bark and hydriodate of potass, and made use of a liniment of glycerine, distilled water, and hydrocyanic acid. Baths and unctuous liniments were also tried; but nothing seemed to be of the least benefit, and she ceased to attend at the Dispensary December 17th, 1854.

Observations.—This peculiar *pachydermatous* disease, which consists in an induration of the skin, or subcutaneous cellular tissue, is of rare occurrence, and has not, so far as I am aware, been described by any British author. Ten years ago M. Thirial gave a description of it under the name of "Sclerema of adults;" but, inasmuch as it is also met with among children, this name requires modification. In order to show that the affection, although rare, constitutes a distinct disease, M. Gillette (in the Arch. Gen. de Med., Dec. 1854) adduces two new cases, which he compares with those which have been already published.

The first is that of a child eight years of age, who was admitted into the Hôpital des Enfans, March 24th, 1854. This child, who generally enjoyed good health, had been attacked some days before admission, and without any known cause, with a stiffness of the neck which was at first mistaken for wry-neck; but this stiffness, which was produced by a general and uniform induration of the skin, soon extended to the face, arms, forearms, chest, and back.

From the immobility of the face, the eyelids became half closed and could not be completely opened, the alæ of the nose seemed pinched, the neck was as stiff as if it were encased in the stocks, the forearm remained semi-fixed, and the arm a little separated from the side; the lips were not so rigid, and preserved their mobility; the fingers, likewise, were almost free. In the parts of the body below the diaphragm, there were only some traces of the induration so marked in the regions above the diaphragm; some patches of it were scattered over the abdomen, thighs, and legs; all the indurated parts of the skin are immoveable and hard, and give to the hand a sensation intermediate between wood and leather; having some colour on the cheeks, it is of a dull white on the other parts of the body; no part pits on pressure; the skin everywhere preserves its sensibility, its power of perspiring, and its normal appearance, with the exception of some erythematous patches on the neck and arms. The health of the child during the course of this affection continued generally good; during several months it only remained in bed for some days on account of an attack of bronchitis, which did not assume a grave character.

For a long time vapour baths, alcaline baths, unctuous frictions, and good diet were directed against the disease; but the amelioration was only transient, and alternated with some aggravation of the malady. About the middle of June, the improvement became more lasting; was it to be attributed to the season or the *régime?* M. Gillette thinks that baths of sulphate of iron contributed to it. The cure, however, was complete.

The second case occurred under M. Guillot in the Hôpital Necker. The subject was a robust woman, aged 42 years, frequently much exposed to the inclemency of the seasons. In her the induration occupied the same regions, and presented the same characters as in the child; the same rigidity, general paleness, with slight erythema on the neck. M. Guillot observed a curious fact, on percussing over the mammæ, which, in spite of their volume were as hard as marble, an almost emphysematous resonance was perceived; they had become conductors of the pulmonary sound. This woman remained a month in hospital, and left it without any amelioration having taken place.

M. Gillette, adding these cases to those already published by M. Thirial, Professor Forget, and others, has obtained a total of fourteen cases, from which he draws the following conclusions with regard to this disease:—

1st. This disease is much more common in females than males (in the proportion of twelve to fourteen).

2nd. Age does not seem to exercise any influence on its development.

3rd. Cold would seem in some cases to have caused it; yet this cause is rather presumed than proved.

4th. The disease has constantly attack the upper parts of the body, generally commencing in the neck.

5th. The skin presents some variety of colour, from dirty white to tan colour; its temperature, as well as its sensibility, remains normal.

6th. The termination has in general been a slow resolution, sometimes extending over many months.

7th. The complications met with in some instances have been cough, emaciation, and erythema at certain points of the skin.

8th. Whenever the urine has been examined, no trace of albumen has been detected. .

9th. There is no treatment the action of which is evidently beneficial; the warm season of the year seems to exercise a favourable influence, and ferruginous baths seem to be of more use than any other.

This kind of sclerema is quite different from the œdematous sclerema of new-born infants, and although in the extremities more particularly it feels very like the hardness and induration which sometimes accompany œdema, yet it can be readily distinguished from this by its not pitting on pressure, its position usually above the diaphragm, its normal temperature, the absence of internal serous effusions, the absence of albuminuria, and its progress and termination.

PATHOLOGICAL SOCIETY MEETINGS.

December 9th, 1854.

MR. ADAMS IN THE CHAIR.

Uterus with Fibroid Tumours under peculiar Combinations.

DR. FLEMING, in presenting a recent specimen of uterus with fibroid tumours, said, "It is much more agreeable to contemplate the cases in which our art is successful than those in which it fails, but the study of the latter is not less instructive than that of the former." Such was the remark of Sir Benjamin Brodie, prefatory to his lecture "On the Causes of death after Lithotomy," some of which Dr. Fleming noted as identical with those to be apprehended in all operative proceedings implicating the pelvic outlets, whether in the male or female. He had now to report the death of the young woman from whom he had removed the large vaginal fibro-cellular tumour, exhibited at the last meeting of the Society, and to detail the *post mortem* appearances, as by doing so, he was assisting in carrying out one of the main practical objects of the Society. The poor woman died on the fifth day after the operation, of diffuse inflammation engaging the areolar issues at the superior outlet of the pelvis, complicated with peritonitis. She escaped from the immediate effects to be apprehended, such as the shock attendant on such a formidable operation, and from hæmorrhage. That she should have suffered some uneasiness in the vicinity of the bed of the enormous tumour was rather to be expected than otherwise, and such was the case; but it was only within forty-eight hours or so, before death, that symptoms supervened which excited alarm. Those symptoms bore a strong resemblance to such occurring after lithotomy, when an incision of the prostate extending into the loose cellular structure surrounding the neck of the bladder is either incidentally or necessarily made. Those symptoms were rather insidious in their onset, but quickly became obvious and characteristic. The rapid pulse, the hot and dry skin, with parched tongue; the anxious countenance and half suppressed hiccup, were the most prominent, throughout. There was no absolute vomiting, although there was a morbid desire for the most objectionable drinks, and a total disrelish for the most appropriate. The intellect was unimpaired almost to the last moment, and there was the most placid resignation to her sufferings. As regarded those symptoms, which might be termed local, there was visible, at the period at which they generally manifested themselves, a dry appearance of the wound, and almost a sloughing condition of its edges and adjoining surface, without any redness or tumefaction of the surrounding integuments. The abdomen was full, and had a painfully tense feel; there was much tenderness, particularly in the umbilical and hypogastric regions; there was occasional retention of urine, and intolerance of the bladder of much distention with it, but the quantity and quality were proportioned to the amount of fluid drank.

The treatment adopted was that suited to the peculiar features of the case. It was unfortunately unavailing. The progress of the case to its fatal termination was as obstinate as it was rapid.

The *post mortem* examination was made about six hours after death, with great care, by Dr. Fleming's resident pupil, Mr. O'Devaine, and the appearances were accurately noted, and witnessed by Dr. Churchill and Dr. F. The body was well formed, and "en bon point." The abdomen was full but not distended, and it yielded on percussion a dull sound, which was accounted for, on opening it, by the thick layer of fat rendering the parietes more resisting. There was no discoloration of the integuments, neither was there any emphysematous or other abnormal feel communicated on pressure over the hypogastric or inguinal regions. In the former, the section of the abdominal parietes presented a very peculiar condition of the areolar tissue intervening between them and the structures underneath, and contrasted remarkably, in a lateral view, with their otherwise peculiar healthy appearance. This tissue was as if injected with a dark, greenish, sizy-looking fluid, which was semi-consistent and had a gangrenous odour. In thickness, about half an inch or so, in the region of the bladder, it gradually thinned off on either sides, towards the anterior spine of the ileum, and was traceable towards the umbilicus. The parietal and intestinal peritoneum throughout, was in the first stage of inflammation, which was particularly acutely marked in the umbilical regions, and hardly traceable in the pelvic. On carefully examining the left plane of the pelvic cavity along which the tumour had lain, the peritoneum was found perfect and entire, and no evidence existed that the peritonitis had commenced there. The tract of the bed of the tumour was matted together by what appeared healthy plastic inflammation, and the closest examination could not detect a remnant of its structure. The uterus (evidently that of a virgin) contained many fibroid tumours in the usual situation, and of the usual texture.

The pathological and practical reflections deducible from those and other details were alluded to.

Gangrene of the Lung, Sloughing of the Pleura, and consequent Pneumo-thorax.

Doctor M'Dowel exhibited a specimen of gangrene of the lung, which had proved fatal by sloughing of the pleura, and consequent pneumo-thorax. The history of the case was the following:—A policeman, 24 years of age, and a remarkably fine-looking man, was admitted into the Whitworth Hospital, November 27th, 1854, labouring under pneumonia. He stated that he had been on night duty at Dalkey, from the 1st of September up to the 18th of October, when he got a severe cold, with a distressing cough, and was obliged to give up his duties, and go to bed. The cough was accompanied by much expectoration of a very offensive odour, and tinged with blood. In a fortnight he was so much better that he reported himself as well, and was put on night duty again. The cough almost immediately returned with more violence than before, and in a few days he was seized with a stitch in the right side, shooting back to the scapula on inspiration. For a week this pain continued to distress him, and then gradually disappeared; but, although suffering very severely, he remained on active duty, and continued to do so until the Saturday (two days) before admission, when he felt so ill that he had to be carried to bed.

[In the preceding account we have the history of a neglected pleuro-pneumonia, in the first instance, and of fresh inflammation supervening before perfect recovery had been obtained from the first attack.]

When examined after admission, the patient's condition was most alarming. He was sitting up in bed, gasping for breath; the countenance was intensely anxious; the extremities were cold; pulse 120, small, and compressible; there was severe stitch in the right side. The physical signs indicated pleuro-pneumonia on the right side; friction and fine crepitus were detected laterally; posteriorly, dulness on percussion, with bronchial breathing and broncophony, indicated pneumonia in the second stage. Two days afterwards (29th), the phenomena of pneumo-thorax were detected on the same side. The right hypochondriac region was remarkably protuberant, and the lower intercostal spaces obliterated. The friction sound had vanished, and no respiratory murmur was to be heard; amphoric resonance and blowing were evident. These phenomena were so characteristic that we were obliged to admit that pneumo-thorax had occurred, although the general appearance of the patient, and the co-existence of acute inflammation in the chest, were entirely opposed to such an opinion. On the following day (30th) there was splash on succussion, bourdonnement amphorique, metallic tinkling, but no amphoric blowing; the entire of the right side of the chest was enlarged, and tympanitic on percussion; the heart greatly displaced—its apex struck the parietes in a line below the centre of the left axilla, at least two and a-half inches to the left of its normal position. Pleuritis had now occurred on the left side, and friction could not only be heard but *felt* distinctly by the hand placed over the left side. Dyspnœa was now most intense; the respiration greatly hurried; the face livid; pulse extremely rapid; delirium occasionally present. These symptoms continued unrelieved, and death occurred on Saturday, the fourth day after the signs of perforation were first developed.

Post-mortem Examination.—The right side of the thorax was evidently greatly distended; it was smooth, and uniformly bulging from the obliteration of the intercostal spaces. Before cutting into the right side of the chest, the ribs on the left side were removed, and the abdomen opened. The following appearances were then observed:—The heart was considerably displaced towards the left side; so much so, indeed, that none of it lay beneath the sternum—its apex was in a line with the centre of the left axilla; the mediastinum, which was tightly stretched, was convex towards the left side; the diaphragm on the right side was much depressed; the liver had undergone that peculiar kind of rotatory displacement so generally met with under such circumstances; for, whilst its left lobe occupied nearly its usual position, the right lobe was pushed very much downwards, and, consequently, the longitudinal fissure was directed almost transversely from right to left. When the right pleura was punctured fetid gas escaped with much force, and the liver gradually ascended to its proper position; about a pint and a half of sero-pus lay in the cavity. The lung, uniformly coated over with thick yellow lymph, was much compressed; it had not, however, abandoned all relation with the parietes, for, inferiorly, and towards the right side, a strong band of adhesion connected it with the thorax. In the immediate vicinity of this adhesion, the pleura and the lung were in a gangrenous condition. The pulmonary tissue hung in loose shreds; a free communication here existed between the interior of the lung and the pleural cavity; and, when water was poured into the trachea, it escaped freely at the gangrenous portion. The anatomical characters of recent pleuritis also existed on the left side; the lymph was very rough, and coated both pleural surfaces; the lower lobe of the left lung was solidified; recently, lymph was also effused on the pericardium; the lungs were free from tubercles.

Doctor M'Dowel observed, that instances of pneumo-thorax were so rarely met with, except in cónnexion with phthisis, that every case, in which that lesion depended on other causes, was worthy of being recorded. The case then recorded was an example of perforation of the lung, the result of gangrenous inflammation. A few similar cases had been recorded, but the lesion was undoubtedly a rare one. A case similar to the one then detailed is described by Doctor Stokes,* but with this difference, that the signs of gangrene of the lung were fully developed before the occurrence of pneumothorax.

December 16*th*, 1855.

MR. ADAMS IN THE CHAIR.

Ulceration of the Œsophagus; Fistulous Communication with left Lung; Pneumo-thorax, and acute Pleuritis.

DR. GORDON said, he was indebted to Dr. Mollan for an opportunity of exhibiting a specimen of ulceration of the œsophagus, which presented some unusual characters. The ulceration was of the chronic form; it commenced at a point corresponding to the bifurcation of the trachea, and extended for about an inch and half downwards. There was, first, superficial ulceration of the mucous membrane; there was one long oval ulcer half an inch in extent, and the mucous membrane at one border of this ulcer was raised up and projecting; there were also several fistulous orifices, and these were each divided by a thin delicate thread of membrane, such as is frequently observed in cases of thinning of the cardiac valves. These fistulæ extended to different depths; one immediately beneath the projecting fold of mucous membrane, passed downwards, and to the left side, and communicated with an abscess which occupied the central and inferior portions of the left lung. This ulcerative process in the lung appeared to be rapidly extending; the pulmonary structure was falling in, in shreds and detached morsels, without any surrounding induration, or any of the usual anatomical characters of pneumonic abscess, and the contents of the abscess were of a very dark colour, and horribly fœtid. This abscess appeared to be rapidly extending in different directions through the lung, and had already reached the inferior surface by two distinct routes; and having in each place perforated the pleura, had given rise to pneumo-thorax and intense inflammation of the whole surface of the lung. There was seen purulent matter in large quantity lying in the cavity of the pleura, and the lung (particularly the anterior and diaphragmatic surfaces) was coated with soft greenish, yellow lymph.

Notwithstanding this projecting fold of mucous membrane, and the several fistulous orifices which exist in the œsophagus, the affected portion of the tube is found to be rather dilated than contracted, and the disease is confined to a portion of the tube, one inch and a-half in extent, there being no narrowing or other disease, either above or below this point; but the symptoms which attended this case during life were such as usully indicate great narrowing of the œsophageal tube.

Reported by MR. DUNCAN, *Clinical Clerk.*

Teresa M'Quade, æt. 40, had been an inmate of the Richmond Lunatic Asylum for the last four years, suffering from melancholy, accompanied by occasional, but short, paroxysms of excitement. She was very delicate, and much emaciated, never ate much food, and several times during her residence in the Asylum, almost completely refused it. Within the last year she had two attacks of purpura hæmorrhagica, the extremities being thickly spotted with petechiæ, and the hams, and back of the thighs and legs covered with large livid blotches. She had, also, repeated attacks of sponginess of the gums, and was, indeed, completely broken down in constitution. Last winter she had a very severe attack of bronchitis. These general symptoms having existed for a considerable time, were succeeded about five months ago by symptoms of local distress, the cutaneous affection having now entirely disappeared, as is frequently the case. The nurse states, that about this time she seemed to suffer from repeated and sudden attacks of dyspnœa, and some time after began to complain of dysphagia. She frequently said that meat and other solid food stopped opposite the upper part of the sternum. Soft solids, or fluids, easily swallowed at this time, became afterwards, however, impeded, and she began to vomit repeatedly, but not constantly, immediately after eating. She had occasional vomiting at other times also, which was exceedingly distressing, and she then, with great difficulty, brought up a quantity of viscid, glairy matter, tinged with blood. She was commencing to refuse all kinds of food, when she was suddenly attacked with the general symptoms of pulmonary inflammation, and violent cough, which was always induced by attempting to take food or drink, and after a few days' illness, expired on the 13th November.

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* Stokes on the Chest, p. 540.

The identity of symptoms in different diseases of the œsophagus, renders their diagnosis often very difficult; thus we find, that the extraordinary case related by Mayo, of great dilatation of the œsophagus, unaccompanied by any stricture or narrowing, was attended with all the symptoms which are usually found in cases of the closest organic strictures of the œsophageal tube. We are the less surprised, therefore, when we read of cases of ulceration of the œsophagus being confounded with stricture—the present case, however, seems to support the idea, that while in stricture of the alimentary canal there is generally reference to a local distress, or inconvenience, before the general phenomena of emaciation and vital depression become developed; in ulcerative œsophagitis, the succession of symptoms is reversed, and the constitutional take precedence of the local by a long period of time—this is particularly so, when, as apppears to be the case in the present instance, the ulceration commences in the mucous follicles; these constitutional symptoms are, of course, very diversified in their character; they are sometimes, though rarely, of a specific nature, typhoid, tubercular, or even syphilitic. But we learn also from this case, that the local symptoms in the two diseases differ, for while in confirmed organic stricture the dysphagia is progressive—first, pain, then difficulty, and at last an impossibility of swallowing solid food, and the patient soon learns from experience the inutility of attempting to swallow certain kinds of food, or morsels of a certain size, for what has been once fairly tried without success, he will seldom again venture on; in ulceration of the œsophagus, on the contrary, the food which is rejected to-day, may pass down without much trouble to-morrow; and it is surprising, in such cases, to observe the apparent caprice of the œsophagus in the nature of the food which it permits to pass; thus I have seen a person who could not swallow chicken broth, or arrow-root, eat, with great pain certainly, but with comparative comfort, dressed lobster and other such irritating food; and what the ulcerated œsophagus rejects to-day, it may to-morrow readily admit, and *vice versa*.

This constant variation in the degree of dysphagia is of course different from a restoration of the power of swallowing, which sometimes takes place in stricture of the œsophagus, after it has been long lost. This is owing to an extensive process of ulceration, which takes place, and is usually indicative of a rapid termination of the disease. A specimen of this kind was exhibited to the Pathological Society, on the 3rd of March, 1849, by Professor Smith, and is preserved in the Richmond Hospital Museum.

There appear to be four distinct phenomena always attendant on ulceration, which are not so constant in stricture of the œsophagus. These are, first, local pain; this is seldom or never absent, if the ulceration be extensive; it varies much in character, sometimes it is excessive; it has been described by patients as if a hot iron were constantly in contact with the part: now in stricture it frequently occurs that there is no pain complained of, unless when the patient attempts to eat or drink, so that those patients often say if they could refrain from eating, they would be free from pain. But in ulceration of the œsophagus, while eating increases his distress, the patient, unless when asleep, is never free from pain. The other symptoms are a constant sensation of weight or oppression on the chest, this sometimes amounts to great dyspnœa, or even a form of angina pectoris; there is also a constant hawking up of ropy viscid mucus, which is frequently tinged with blood, and this being exceedingly tenacious, causes usually a great amount of distress; there is also, generally, profuse ptyalism; this is said by many to occur only when the upper part of the œsophagus is diseased, but it existed in this case where the ulceration is not found in the superior part.

The exact mode in which this case terminated is rather unusual; a fistulous tract passed from one of the ulcerated mucous follicles downwards and towards the left lung, where an unhealthy inflammation caused the rapid formation of an abscess. This occurrence, of course, gives rise to an entirely new set of symptoms, indicating pulmonary irritation; the most marked of these usually are, the immediate production of violent fits of coughing by any attempt to swallow food, and this cough is attended with copious expectoration, in which morsels of the food or drink swallowed are thrown up with the ordinary pulmonary expectoration.

This is now the fourth specimen in the Museum of the Richmond Hospital of a fistulous communication formed between the left lung and œsophagus. Vigla, in the year 1846, collected a large number of such cases, and he found that when the œsophagus was perforated, it most frequently communicated with the right lung. Such was the case in ten instances out of eighteen. In the present instance the fistula was of most unusual extent, passing entirely through the left lung, it communicated with the cavity of the pleura, giving rise to all the phenomena of acute pleuritis with pneumo-thorax.

(*Museum, Richmond Hospital.*)

THERAPEUTICAL RECORD.

Of the Employment of Borax in Injections, in the Diarrhœa of Children. By M. Bouchut.—It is well known how difficult it sometimes is to check certain forms of diarrhœa in young children, during the period of their first dentition. Two kinds of diarrhœa are met with amongst children at this age, the one symptomatic of organic disease of the intestinal mucous membrane, the other an idiopathic affection, catarrhal in its nature, sometimes proving fatal, yet leaving behind no appreciable lesion. In this last complaint it is that the *lavements* of borax recommended by M. Bouchut are so successful. The beneficial action of this remedy on the mucous membrane of the large intestine is regarded by M. Bouchut as analogous to the good effects of borax on the mucous membrane of the mouth, especially in aphthous affections. Borax has this advantage over other salts generally used in injections, in such cases it does not decompose in the syringe, it is not irritating, and it is alcaline. The following is the formula for this alcaline *lavement*:—

Borax, ʒiv. to ʒvi.
Sugar and water, ℥iv.

If a larger quantity of borax be administered, it is necessary to increase the quantity of fluid, since the borax is not very soluble. M. Bouchut has used this salt in other intestinal maladies, as ulceration, but his cases are not sufficiently numerous to be conclusive.—*Gazette des Hôpitaux.*

Ergot of Rye in Hæmoptysis.—M. Legroux published several years ago the result of his experiments on ergot of rye, as an hæmostatic agent in hæmoptysis; since this time he has continued to employ this remedy in like cases, and two cases lately observed in his service, at the Hotel Dieu, give proof of its therapeutic value.

One of these was a pale, anæmic woman, advanced in pregnancy, who had been spitting blood constantly, in small quantities, for several months; she was at first treated with ipecacuanha powder and tartar emetic, without much benefit, afterwards with ergot of rye, in doses of ℈i.; this was followed by immediate diminution in the quantity of blood expectorated, and she soon left hospital, on the total cessation of the hæmoptysis. The second case was that of a young man attacked with profuse hæmoptysis, accompanying the rapid development of pulmonary tubercles; the hæmoptysis was at once arrested by ten grain doses of ergot of rye; after some days it again supervened, and was a second time promptly arrested by the ergot.—*Revue Méd. Ch., Oct.*

On the Use of Caïnça Root in Scarlatinal Dropsy.—The root of Caïnça (chiococca racemosa) is highly extolled by M. Bruguier, as a diuretic; he warmly advocates its use in divers dropsies, but especially in that following scarlatina. He says, "that there is not in the whole materia medica any drug that acts with more promptitude or more success." His enthusiasm seems to have induced him to overrate its merits, yet he details six cases in which the use of this root was attended with remarkable success.

Cainça root, bruised, ʒij.
Water, ℥viij.

Macerate for twenty-four hours, and boil: to be taken in three doses, at intervals of two hours. This decoction causes an extremely abundant flow of urine, causing micturition so frequently as even to interfere with sleep.—*Revue Therap. du Midi.*

On the Value of the Treatment of Orchitis by Collodion.—M. Ricord does not advocate this mode of treatment, so highly recommended by M. Bonnafont. Thirty-eight patients have been submitted to it: the pain lasted from six minutes to a quarter of an hour: most of the patients ceased to suffer after the lapse of this time; four however, suffered all day, and one of them complained of very severe pain. In none of the cases did M. Ricord observe the *miraculous flight of the testicle,* resolution and cure spoken of by M. Bonnafont. The mean length of time which the disease lasted, in the cases treated by collodion, was seventeen to eighteen days. In short, M. Ricord is of opinion, that the application of collodion does not shorten the duration of the disease, that it constitutes a very feeble means of compression, that it sometimes provokes very acute pain, that it causes a very inconvenient vesication of the scrotum. M. Velpeau's experience accords with that of M. Ricord.—*Revue Med. Ch., Oct.*

Eczema treated by Traumaticine.—Under the name traumaticine, Eulenberg (*l'Union Méd.*) has employed a solution of gutta percha in chloroform, in the treatment of eczema and psoriasis; the solution is painted on daily, and a thin pellicle forms, which of course gradually becomes detached. The following is the formula for a remedy found very serviceable in allaying the itching and irritation accompanying many diseases of the skin, especially chronic eczema of the legs in elderly people.

℞ Glycerinæ,
Aquæ rosæ, āā ℥iij.
Acidi hydrocyanici, ʒij.
M. Fiat lotio.

It is also useful in excoriations of the skin, chapping of the hands, &c., for which the following is likewise recommended:—

Ointment of white wax, ℥ij.
Purified honey, ℥i.

Melt and mix well together, adding, while cooling,

Glycerine, ℥i.
Oil of bitter almonds, gtt. xv.

It is necessary to keep stirring while it is setting, otherwise the glycerine does not mix in.

Iodine Inhalations.—In pulmonary diseases, in which iodine inhalations are recommended, Dr. Barrere speaks highly of the following plan:—Some powdered camphor is placed in a small box, and over it a small muslin bag containing some iodine; the vapour of the iodine combining with that of the camphor, forms a compound which is easily inhaled. At first a feeling of warmth is experienced in the air passages, which becomes soothing and agreeable, and does not excite cough.

Treatment of Scarlatina. By M. TROUSSEAU.—When scarlatina follows its normal course, as in other simple exanthemata, it is merely necessary to avoid interference. In variola and measles, when uncomplicated, expectation is the treatment; so also in simple scarlatina. Soothing drinks, mild laxatives, a comfortable and even temperature are the only means required. But if there should supervene nervous excitement, very rapid pulse, dryness and heat of skin hardly to be borne, then energetic measures must be resorted to. Unfortunately, measures likely to be followed with good results are few in number. To lower the pulse, calm the nervous system, moisten the skin, and ameliorate the general symptoms, no means is so powerful as affusion of cold water. In a great number of cases it has rendered incontestible service; yet so strong is the opposition offered to it, that it is with difficulty that one's patients can be allowed to profit from it. The patient should be stretched in an empty bath, and for some seconds water of the ordinary temperature should be thrown over the body with a cup; immediately he should be enveloped with care in warm woollen coverings, and have some glasses of cold water given to him to drink. In a quarter of an hour, generally, the delirium ceases, the pulse falls in a way hardly to be believed, the skin becomes moist; an abundant diaphoresis is established, and the patient feels sensibly improved. Often the patient's parents, who have been much opposed to the cold affusion, are so struck by the improvement, that they are the first to seek its repetition; and indeed, it should be repeated for three or four days, two or three times in the twenty-four hours. If, however, there is on the part of the family an invincible repugnance to the cold water treatment, yet if the physician thinks well of having recourse to it, he may employ another mode, differing more in appearance than reality: place the patient on a bed, naked, and pour over him tepid water; the temperature of the skin in scarlatina is so high that this will exercise a beneficial cooling influence.—*Abeille Med.*

Mode of administering Cod-Liver Oil.—Cod-liver oil is so precious a medicament, especially among children, that every imaginable contrivance to facilitate its use has in our eyes great value. The following is a good formula for a vehicle which completely masks the disagreeable taste and odour of cod-liver oil:—

Yolk of one egg.
Sugar, ℥i.
Orange flower water, ʒj.
Cod-liver oil, ℥iij.
Essence of bitter almonds, gtt. j.
Ann. Cliniq. de Montpellier.

On the Employment of Wine in Enemata, especially in the Treatment of Chlorosis, Dyspepsia, Pulmonary Phthisis, and during Convalescence from severe Diseases.—The employment of medicated enemata, says M. Aran, the well-known physician to the Hôpital St. Antoine, is of very ancient date; but I have sought in vain for any mention of the administration of wine by this means amongst the older authors. Hoffman alone recommends it for subjects whose strength is failing; it is not, however, to this renowned physician that I owe the idea of making use of wine-enemata in various diseases. I read M. Cazin's exposition of a mode of treatment adopted by him in chronic diarrhœa, which consisted in the employment of wine and eggs in lavements. I had at this time under my care in the Hotel Dieu, a woman 35 years of age, affected for thirteen weeks with diarrhœa that nothing could control; she was exceedingly anæmic and had œdema of the feet, but no albuminuria nor heart affection. Three lavements of wine were administered to this patient daily, and although neither instantaneous nor complete, the result was, nevertheless, very remarkable; the number of the stools diminished, strength returned, œdema disappeared; the patient in a great degree resumed her natural complexion, and was occupied about the ward. I was so struck by the influence of the lavements on the general condition of this patient that I asked myself, whether during convalescence from serious diseases, when the digestive functions are languid, the convalescence might not be shortened by this means; if in cases where the stomach would not bear aliment, it might not be possible to get up the patient's strength by such treatment. Repeated trials have now convinced me of its usefulness, and in no cases more than those of pulmonary phthisis, where I have employed it with great advantage to check diarrhœa.—*Bull. de Thérapeutique.*

Proto-sulphate of Iron in the Form of Ointment for Skin Diseases.—M. Devergie, Physician to the St. Louis Hospital, Paris, strongly recommends the above agent in some forms of skin disease, viz., such as are connected with the lymphatic constitution. He mentions it as especially valuable in eczema, eczema-impetigenoides, and impetigo. He gives the following formula for the preparation of this *pommade*:—

Axunge, ℥i.
Proto-sulph. ferri, 7 to 15 gr.

The salt having been powdered and washed, is to be dissolved with the aid of a few drops of water, and immediately incorporated with the lard. After which, without delay, it is to be put into a well stopped bottle, to preserve it as much as possible from contact with the air.—*Bulletin de Therapeutique.*

Chamomile in large Doses for facial Neuralgia.—Dr. Lecointe, in the *Bulletin Therapeutique*, details several cases in which he has given chamomile in large doses for facial neuralgia, with marked success. It may be given either in boluses containing about ʒi. of the powdered chamomile, or in infusion, when ten of the flowers being infused in a small cup of boiling water, makes the dose, to be taken three times daily.

Diacylon made with Oxyde of Zinc.—M. Guèneau de Mussy, having observed the evil effects resulting from the application of diacylon plaster made with oxyde of lead to large ulcerated surfaces, in several cases, saturnine poisoning being the result, was led to make trial of oxyde of zinc instead, and gives the following description of the mode of preparation of this new and safe diacylon plaster:—"A solution of white soap was introduced into a solution of sulphate of zinc, when there was obtained an abundant precipitate of the oleomanganate of zinc, which, when washed and dried, was combined with the gum-resins and other substances which enter into the composition of diacylon."

On account of the very dry nature of the salts of zinc, the quantity of oil must be proportionately augmented to preserve the due consistence of the plaster.

New Mode of preparing Dupuytren's antisyphilitic Pills.

Bichloridi hydrargyri, gr. ix.
Extracti opii, gr. xii.
Extracti guaci, gr. xiii.

Dissolve the bichloride of mercury in a sufficient quantity of alcohol. Dissolve the extracts in a sufficient quantity of boiling and filtered distilled water. Mix the two solutions then in a porcelain capsule, and evaporate to the proper consistence for pills, stirring the mixture during the process with a glass rod.

Divide the mass into sixty pills; each pill will contain about one-seventh of a grain of the bichloride.

Liebig's Albuminous Soup.—The *Bulletin Therapeutique* says, this soup may justly be considered a valuable therapeutic agent; it is prepared in the following manner:—

Take half a pound of fresh meat, beef or fowl; wash it; then place it in a pint of distilled water, containing four drops of hydrochloric acid and about thirty grains of common salt, and leave it to macerate during one hour. After this, turn out the whole mass and strain through a linen cloth, repeating the process for the first portions of the soup, which are never clear; when the liquid has all passed through, wash the meat with distilled water to obtain a pint of soup.

A cupfull of this will be a nourishing dose for an invalid; it should be kept in a cool place.

Cyanide of Mercury is said to possess advantages over the other salts of the metal as an antisyphilitic remedy, never being followed by diarrhœa or distressing ptyalism. The form for it administration which has been recommended is as follows:—

Cyanide of mercury, gr. v.
Sydenham's laudanum, ʒss.
Distilled water, ℥vi.

Of which a teaspoonful is to be taken night and morning, in a cup of milk; this dose may be augmented by degrees, according to the tolerance which the stomach shows for the remedy, until a tablespoonful night and morning is arrived at.

Oxyde of Zinc in Epilepsy.—In the epileptiform affections of infancy, M. Blache, of the *Enfans Malades*, Paris, recommends the following formula:—

℞ Oxydi zinci, ʒii.
Calomel. ʒi.
Pulvis valerianæ, ʒi.

Mix, and divide into seventy packets; one to be taken night and morning.

Warren's antihæmorrhagic Balsam.—The foling is the formula for the preparation of this celebrated American styptic:—

Acidi sulphurici, ℥i.
Olei terebinth. rect. ʒii.
Spiriti rectificati, ʒii.

Place the acid in a clean porcelain capsule; add by degrees the essence of turpentine; whilst agitating the mixture, leave the capsule to cool, and then add the alcohol in the same manner. When the balsam has cooled, place it in a well stopped bottle, and after some days raise off the pellicle which collects upon the surface of the balsam.

Ergot of Rye replaced by Uva Ursa.—Mr. Harris, in the *Virginia Medical Journal*, relates cases in which he has employed a strong decoction of uva ursa in accouchments, where the ergot of rye would ordinarily have been employed, and found its employment followed by vigorous pains, which soon caused the expulsion of both fœtus and placenta. Mr. Harris prefers this medicine to ergot of rye, inasmuch as it does not cause such strong contractions as the latter, which are so very painful to the mother and dangerous to the child.

Adulteration of Valerian.—Valerian root has lately been discovered to be extensively adulterated with the root of *scabiosa sinusa* of Linnæus, amounting often to 22 per cent. of the quantity examined. To discover the adulteration, it is only necessary to examine the root with care; that of valerian is formed of white cylindrical radicules, pointed at their extremities, with their surface furrowed.

Subnitrate of Bismuth in Leucorrhœa.—M. Caby (Bull. Gén. de Thér., Août) recommends strongly the local application of bismuth, by means of the speculum and lint, on the neck and mouth of the uterus, and on the vagina, as the speculum is being withdrawn. There is no pain. The application should be made daily. Before using the bismuth a water injection may be used, to clear away the discharge from the membrane.

Lime, Phosphate of. — Dr. Kuchenmeister (Schmidt's Jahrb., 1854, vi. p. 298) recommends the following formula in cases in which phosphate of lime is indicated:—

Calcis phosphat., ʒij.
Calcis carbon., ʒj.
Sacch. lactis, ʒiij.
M. ʒss. bis terve in die.

Instead of the milk sugar, lactate of iron may be substituted, if iron be required. The especial use of the carbonate of lime appears to be that carbonic acid is liberated by the acid of the stomach, and dissolves the phosphate. Lactic acid also is formed from the sugar, or is set free from the lactate of iron, and dissolves the phosphate. The most ready way of absorption is, however, when the phosphate is given with food, especially with milk, with which it forms a soluble combination.

Rheumatism, Chronic. Turpentine Vapour Baths. —Dr. Rey (L'Union, No. 46) has used turpentine vapour baths with great effect in chronic rheumatism, neuralgia, and chronic pulmonary catarrhal affections. The vapour is brought by means of pipes into a room, into which fresh air can be rapidly introduced if necessary. The heat and the amount of turpentine are regulated by circumstances. The flow of sweat is very copious, and the turpentine is also absorbed, and gives the violet odour to the urine. On account of the immense sweating, the baths are very weakening, so that few persons can take more than twelve (on successive days) without leaving them off for some time.

Tinea. Sulphurous Acid. — M. Verhaeghe (Annales de la Société Méd. Chir. de Bruges, 1854) relates three cases of tinea treated by the local application of sulphurous acid, after the manner of Jenner. In two cases a rapid cure was effected; in the third case there was temporary amelioration, but the disease subsequently returned.

M. Bagin (Revue Méd. Chir. de Paris, Août) has published a memoir on tinea, to show the success of his treatment. This consists in the most careful epilation, and the destruction of the parasitic plant by a solution of the bichloride of mercury, or of the acetate of copper. The details of the treatment are as follows. The hair is first cut close; sulphur lotions and cataplasms to attack the crusts are applied; the solution of corrosive sublimate is then applied so as to kill all the plant on the surface. Then either the hairs are pulled out with pincers, or if the disease be recent and the epilation difficult, the oil of cade, or an alkaline pomade of lime and soda, is rubbed on. When a certain space has been cleared of hair, it is washed with soap and warm water to get rid of fat, and then the parasiticide solution (1 part of corrosive sublimate or of acetate of copper to 100 of water) is immediately applied.—*Brit. & For. Med. Ch. Review.*

Treatment of Favus.—From the observation of about a dozen cases of severe favus (diagnosis by the microscope in all) recently treated by Mr. Startin, at the Hospital for Skin Diseases, we can speak with great confidence of the efficiency of the following ointment. It is the Ung. Sulph. Comp. of the Pharmacopœia of that Institution.

℞ Sulph. sublimati, ℔ss.;
Hydrarg. Ammonio-Chlorid., ℥ss.;
Hydr. Sulphureti cum Sulph. ℥ss.;
Leviga simul, dein adde Olivæ Olei, ℥iv.;
Adipis Recentis, ʒxvj.;
Creosoti, Mxx. M.

To correct the state of general health, Mr. Startin commonly orders simultaneously a mild course of the iodide of potassium, but this, we suspect, has but a small share, if any, in the local result. Often when the scalp has been for many years thickly covered with the peculiar favus crust, four or five nightly applications of the above ointment have sufficed to make it perfectly clean. So long as the patient will continue regularly to use a small quantity every day, the disease may be prevented from reappearing, and the condition assumed by the scalp under its influence might easily be mistaken by the inexperienced for one of complete cure. As soon, however, as the inunction is suspended, the eruption reappears. This liability we have known, in more than one case, to extend over nearly a year, and probably it may for much longer periods. The ointment, however, which does not smell much, need only be applied at night, and may be entirely washed away every morning, so as to entail but little inconvenience on the patient. The hair will, to a considerable extent, grow during the treatment, provided that the scalp have not been too much destroyed. In a most disgusting disease, for which as yet no real cure is known, it is much to be in possession of an almost certain means of ensuring its absence. The ointment, no doubt, acts as a parasiticide. Before its first application it is desirable to clear away the crust as much as possible, either by fomentation or a poultice.

We may remark, that the ointment mentioned is used by Mr. Startin in the treatment of scabies, and also in that of the contagious form of porrigo. —*Medical Times and Gazette.*

Coniine in Scrofulous Intolerance of Light.—Dr. Mauthner has found great benefit in cases of this kind, where no inflammatory symptoms are present, from the application twice or thrice daily of this emulsion:

℞ Coniinæ, gr. ss.
Ol. Amygdalæ dulc., ʒj.

The application is made by means of a common camel-hair pencil. Dr. Mauthner says, that the most obstinate cases may be cured in this way in a period varying from eight to fourteen days.—*Journal fur Kinderkr.*

Lupus. Biniodide of Mercury. Dippel's Animal Oil.—Cazenave (Bull. Gén. de Thér., 1854, p. 530) employs as a local application a strong ointment, composed of equal parts of the biniodide of mercury and of a mixture of lard and almond oil. In winter the proportion of oil is increased, in order that the ointment may be liquid, and may spread easily over the skin. The ointment produces intense congestion and redness of the skin, and severe pain. If the parts are covered with cuticle, vesications and pustules are produced, which crust over. If the parts are ulcerated, a thick albuminous secretion is poured out, which forms a crust. When the crusts are detached in five or six days, the lupose tubercles are found to be much reduced in size. Two or three applications of the ointment, at intervals of a week, are sufficient to reduce them to the level of the skin. No unfavourable symptom has been known to be produced by the absorption of the biniodide.

Cazenave also sometimes employs as a local application, Dippel's animal oil, in the place of the biniodide; and these two remedies constitute the only local measures. The cod-liver oil is employed internally.—*Brit. & For. Med. Ch. Review.*

Gallic Acid in Pyrosis. By Dr. Bayes.—In pyrosis, where this disease is unaccompanied by extensive ulceration, or organic malignant disease of the stomach, or by disease of the liver, the most marked benefit will follow the use of the remedy. Gallic acid, here, not only checks the secretion with a certainty and rapidity I have never seen follow the administration of any other remedy, but it gives general tone to the stomach, increases the appetite, and (what I very little expected when I first used it) in many cases removes constipation. This I can only account for on the supposition that the relaxed atonic state of the stomach which favours pyrosis is continued throughout the alimentary canal, the constipation in these cases arising from want of power in the muscular coats of the intestines to expel the fæces. This want of tonicity is remedied by gallic acid. The cases of pyrosis which have fallen under my observation, since I have adopted the gallic acid treatment, have been very few; indeed I believe it to be a very infrequent form of disease in Brighton. Out of 945 cases of general disease, which have come under my care at the dispensary during the past twelve months, only eight patients have suffered from this disorder. These have been all females. I have the notes of five of these cases before me. The first was a female of twenty-five years of age, unmarried; she had been for eight months suffering from pyrosis and obstinate constipation, during which period nearly every remedy of reputed value had been administered. She was completely cured in two days. I kept her under my care for three weeks, continuing the gallic acid and occasional doses of castor-oil. I have seen her since, and though some months have elapsed, she has remained perfectly well. The second case was a female, forty-nine years of age. The pyrosis ceased after the second dose of the medicine. She discontinued the treatment a week afterwards, and had a slight return the following morning, which again gave way to the medicine, and by a continuance of the pills for three weeks, she has remained perfectly well ever since. In the third case, the remedy proved equally successful. In the fourth, a married woman of thirty-five, who had suffered from the disease nine months, the distressing symptoms abated considerably at the fourth day, and entirely left her on the eighth day. In the fifth case, a female of forty-five, there was no return after the first dose. In one case only have I found it to fail, and this woman is still under my care; she is forty-nine years of age, and is, I fear, the subject of malignant disease, together with organic disease of the liver. All the first five cases presented a general similarity in the relaxed muscular fibre of the body, and pale watery appearance of the mucous surfaces. —*Association Med. Journal.*

DUBLIN: PUBLISHED BY W. B. KELLY,
8, Grafton-street.

LONDON: S. HIGHLEY, 32, Fleet-street.

EDINBURGH: MACLACHLAN & STEWART.

February 1, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.
SENT FREE BY POST.
Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 2.—VOL. II. FEBRUARY 15, 1855. PRICE 5D.

WHITWORTH HOSPITAL.

Tuberculosis limited to the Base of the Right Lung.

BY J. T. BANKS, M.D.,

KING'S PROFESSOR OF PHYSIC; ONE OF THE PHYSICIANS TO THE HOSPITAL.

THE diagnosis of phthisis in its *first period* is frequently difficult, and requires in many cases the utmost care and attention on the part of the physician to avoid arriving at an erroneous conclusion. There is no disease upon the investigation of which a greater amount of labour has been expended, and for an obvious reason—its great importance. One of the most distinguished cultivators of medical science,* in speaking of this disease, whose natural history he has mainly contributed to illustrate, thus expresses himself—"The greater the danger attached to any given class of diseases, the greater the importance of being able to distinguish these with precision, and the more necessary does it become to study that part of their history termed their diagnosis with all possible care."

That phthisis eludes the observation of all but the highly educated in physical diagnosis at its earliest stages is, I apprehend, admitted on all hands, but that cases *may* present themselves of this disease at an advanced stage—the excavation period—in which there *can* be any hesitation on the part of the auscultator as to the true nature of the disease, is a statement which I freely acknowledge is calculated at first sight to startle the reader.

Such a case, however, has lately been under observation in the wards of the Whitworth Hospital, and a brief glance at the most salient points in its history will, I doubt not, justify the belief that rare and exceptional examples of disease are met with, which, setting all ordinary rules of diagnosis at defiance, compel us to doubt and hesitate before we give a positive opinion as to their nature.

A man, aged 40, was lately admitted into the Whitworth Hospital; he had been ill for some time previously, but had not been incapacitated from following the arduous occupation of a labourer. The symptoms under which he suffered before his admission were cough, hurried respiration, and pain in the right side.

On being questioned, it appeared that he had never had hæmoptysis, nor, in short, any ailment until his present, and that there did not exist any hereditary taint. A few days before entering the hospital, he perceived that his expectoration had acquired a most offensive odour.

His appearance was that of a man who had long laboured under disease. His skin was sallow and greasy; his pulse accelerated, never under a hundred; respiration rapid; he complained of debility, loss of appetite and of night sweats. On examination of the chest the upper regions were found, both on auscultation and percussion, to be perfectly free from any morbid sound. The base of the right lung was dull, and a coarse muco-crepitating rale was audible; there was also an augmentation of vocal resonance. He complained of cough, followed occasionally by the expectoration of matter which was distinctly purulent and of an abominable fœtor. After a violent paroxysm of cough he often got up a very large quantity of the purulent fluid, which was always followed by relief.

---

* Louis.

He gradually lost flesh and strength; he suffered at times from diarrhœa. The auscultatory signs of a cavity at the base of the right lung became manifest, cavernous breathing was audible, with gurgling and pectoriloquy, which was so marked as to be almost painful to the ear of the auscultator. The purulent fœtid fluid continued to be expectorated in great quantity, and after a residence of seven weeks in the hospital, he sank under the influence of his wasting malady. The apices of the lungs anteriorly and posteriorly, up to the close of life, were free from any sign of diseased action.

The autopsy revealed the existence of tubercular infiltration of the base of the right lung, with numerous cavities. In no other part of the lung was there a trace of tubercular deposition.

The experience of every practical physician and the records of disease abundantly prove how unlike the ordinary cases of phthisis is that which I have now detailed.

No fact in pathology is better established than that the "favourite habitat" of tubercles is the apex of the lung.

So few are the exceptions to this law, that they have altogether escaped the notice of many writers on the subject of thoracic disease.

We have only to turn to the rules laid down to guide the student in auscultation, in many of our standard books, to see that in the diagnosis of phthisis the probability of tubercle being developed, *first*, at the base of the lung is not entertained. A consideration of the perfect immunity from disease of the superior regions of the chest—the signs of an abscess at the base of the lung, combined with the fœtid expectoration, induced me at first to believe that I had to deal with a case of fœtid abscess of the lung, and I indulged a hope that the case might possibly terminate in a restoration of the lung to health, unpromising as it was, taking it in its entirety. It resembled some of the cases of fœtid abscess of the lung, so admirably delineated by Sir Henry Marsh in his lectures.

The fœtid expectoration, so unusual in phthisis, added to the locality in which the signs of abscess existed, aided in inducing me at the commencement to lean to this opinion, which time proved to be incorrect. I had not the advantage of seeing the case at an early period, when, pursuing the sequence of physical signs and symptoms, I might have arrived at the knowledge of the fact that at least it was *not* simple fœtid abscess.

Sir Henry Marsh says, "Fœtid abscess of the lung usually commences as an ordinary catarrh, and without, at first, exciting any serious apprehension. To this general rule, however, there is an occasional exception. After a few days the local signs of pneumonia begin to manifest themselves; and these by degrees assume all the characters of a distinct, circumscribed pneumonia. As far as my experience has gone, the disease invades more frequently the inferior and middle, than the superior portions of the lung. After the lapse of several days, the period varying greatly in ever-varying constitutions—the localized inflammation terminates in abscess. Soon a communication is established with the bronchial tubes; the contents of the abscess are, at first in small quantity, afterwards copiously, by deep and laborious coughing, expectorated. An odour, peculiar, characteristic, and oftentimes extremely offensive, is perceived to emanate from the sputa."

In the cases reported by Sir Henry Marsh, some had hæmoptysis, fever, emaciation, profuse sweating, and diarrhœa; in short, the constitutional symptoms of phthisis. A person seen for the first time with signs of a cavity at the *base* of the lung, and with emaciation and alternating sweating and diarrhœa, cough and fœtid expectoration being present, and of whose previous history as regards the state of the lung nothing is known, presents a difficulty in diagnosis. It may be that localized pneumonia has terminated in abscess, with fœtid expectoration, or, perchance, the abscess is a tubercular one in an unusual locality, and presenting the phenomenon of fœtid expectoration, to aid in throwing a difficulty around the case.

That cases presenting a group of signs and symptoms, which have been observed in fœtid, or "simple abscess" of the lung, may, in reality, be tubercular, is proved by the case under consideration.

Fortunately, however, an error in diagnosis as to the nature of a pulmonary abscess is not likely, at the present time, to be fraught with danger to the patient. The treatment of a case believed to be fœtid abscess of the lung would not, I apprehend, in the hands of a judicious physician, differ in any important particular from that so generally pursued now-a-days in cases of tubercular caverns, and with results which fully attest its great value. I need scarcely say I speak of the analeptic or reparative method. To support the system by all means under the exhausting influence of the disease is assuredly the only mode of treatment in either case, which holds out the slightest chance of rescuing the patient from a condition which must always be looked upon as perilous in the last degree. Grave as the prognosis is of necessity, in any case presenting the signs of excavation of the lung; we may, however, under the conviction that the abscess is a simple one, give a more favourable prognosis than would be warranted under the supposition of its being tubercular. The practical conclusion which may be drawn from considering the case I have made the subject of this brief communication is, that we should be slow to decide against an abscess of the lung being tubercular, because the upper portions of the lung are destitute of the physical signs of tuberculosis, and because the expectoration possesses a character, viz. fœtor, which so frequently belongs to abscess of the lung—the termination of a localized pneumonia.

CITY OF DUBLIN HOSPITAL.

On the Use of Chloroform in the Treatment of Delirium Tremens.

BY JOLLIFFE TUFNELL, F.R.C.S.I., M.R.I.A.,

SURGEON TO THE HOSPITAL.

When a new remedy is introduced into practice for the treatment of any disease, it seems almost to be an established rule that the first few cases recorded shall be of the most cheering character. The medicine is prescribed, and the affection forthwith disappears. As soon, however, as its employment begins to be general, less satisfactory results follow, and the new agent is then as quickly laid aside, after having been more or less abused.

Now such it appears to me is likely to be the case with chloroform in the treatment of delirium tremens, for in consequence of one or two cases having occurred, where it has not immediately controlled the disease, distrust of its power and usefulness has begun to be engendered, and not only so, but it is even stated, "that in cases which are caused by suddenly leaving off the stimulant, as in habitual drinkers, chloroform is highly dangerous."

Regarding chloroform as I do, on the contrary, as a most valuable agent in the treatment of delirium tremens, as perfectly safe if given with proper precaution, and highly efficacious if used with sufficient energy, I should be very sorry to see any check put to its employment in this affection; and I shall therefore beg to detail the particulars of a case lately under my care in the City of Dublin Hospital, which may tend to confirm confidence in its use, and prove that it can be given, and given freely too, in cases which are caused by suddenly leaving off the stimulant. The case is as follows:—

J. N., æt. 36. a sottish-looking individual, a tailor, was brought to the City of Dublin Hospital by his wife, at 10 A.M. on the 22nd of September last, presenting the ordinary symptoms of this disorder when fully established. The surface generally was bedewed. The eye wandering and restless; the tongue, when protruded, flabby, flocculent, and tremulous; the hands in perfect tremor when held off unsupported from the body. The pulse was full, but soft and very compressible; the conjunctivæ slightly congested. His wife stated that he had been on a drinking bout for some days, but gave it up on the 17th, apparently in consequence of sickness of the stomach having set in. He remained at home ill and unable to do anything on the 18th, and on the 19th the disease appeared, first manifested by his taking possession of a knife, which he said he must keep by him, ready to protect himself and her from a brother-in-law, who was plotting their destruction. From this time he had no sleep, and was perpetually on the watch until brought up to the hospital, a period of nearly eighty hours.

He was at once admitted, and ordered into a quiet ward, to be carefully watched, but not restrained, unless absolutely dangerous to those around him. To have a pint of porter, as he was complaining of thirst, and then a nicely broiled mutton chop, for he had not taken food for some time. Three leeches were next directed to be applied to the temple, and upon their coming off, a cold lotion to the head, after which a drachm of chloroform was to be given, and repeated at intervals at the discretion of the house surgeon, until sleep supervened.

September 23rd.—I visited him at 9 A.M., and received the following report:—He had taken the food and porter, and permitted the leeches to be applied, and afterwards remained quiet until four o'clock in the afternoon, when he began to be restless, and shortly afterwards violent, requiring restraint. For some time he would take no medicine, but at 6.30 was prevailed on to swallow a drachm of chloroform in a draught, and to repeat it at 7.30, again at 9.30—three drachms in three hours, but without producing any appreciable effect; and as the chloroform did not appear to be of any benefit, the house-surgeon did not push it further, but, at the same time (as I had expressed a desire that the treatment should be uncomplicated) refrained from giving any opiate. At the time of my visit the patient was tranquil, but had not slept, and there had been now no sleep for nearly one hundred hours. The bowels had not been moved since admission; a turpentine injection was, therefore, directed to be given; the hair, which was very abundant, ordered to be reduced, and cold affusion to be employed for some time to the head, after which, as a brisk breeze was blowing, the bed was to be brought under the window, and the linen blind so directed as to keep a continual stream of cold air playing over the scalp. The following draught was to be taken at intervals, according to the effect produced:—

The yolk of an egg.
White sugar, 1 drachm.
Whiskey, 4 drachms.
A little nutmeg.

All to be mixed well together; and to this a drachm of chloroform added at the time of being taken.

Strong beef-tea to be given in small quantities, as wished for, and chop and porter taken as on the preceding day.

September 24th.—At my visit at 9 A.M., I found the patient quietly asleep, and received from the house-surgeon the following statement: "Shortly after taking the chloroform he became violent, but only for a minute or two, he then tumbled off into a placid sleep, and remained so for half an hour. On awaking he was again very noisy and restive; a second dose was now given him; he became stupid for fifteen minutes, but did not sleep, and again became violent. As soon as possible the draught was repeated, and on taking it he fell off asleep. In an hour he awoke, restless and noisy, but not so violent; after a short time, a fourth dose was administered, and under it he lay quiet, but did not sleep, and he soon began to be as furious as ever. A fifth dose was now given, plain, in cold water, which made him torpid, but from which he recovered and burst out again. A sixth drachm in water was then given, soon after which he dropped off into a slumber, and remained sleeping soundly through the night, and up to the time of my visit.

At 2 P.M. I called at the hospital to see another case, and looked into the ward to ascertain how he was going on. I found him awake and quite rational; he complained a good deal of soreness of the body generally, especially of the wrists, where he had been held when violent, but made no other remark. His bowels had been freely moved.

On the 26th, he was convalesent, and on the 28th was discharged perfectly well.

Now here was a case, "brought on by repeated fits of intoxication, succeeded by a pause of perfect sobriety," one of deprivation of sleep for upwards of one hundred hours, and with extreme nervous excitement, yet in which chloroform was given freely and with the happiest results; and I am satisfied it may be used generally, if administered with care. By the last expression I mean having a due regard to the support of the powers of life of the individual, by food (if he will take it), and by stimulants in the form of the egg flip with whiskey as prescribed. Chloroform is a powerful sedative, and therefore certainly not to be carelessly employed, but with due caution it may be safely and advantageously used.

As regards the objection "that chloroform often fails, and is not, therefore, to be relied upon for the treatment of delirium tremens," this I believe to have been the result solely of its not having been used in sufficiently large doses, or often enough repeated. Speaking generally, I think the intervals between its administration have been too long. Half a drachm of chloroform given every fourth hour may certainly be tried at first; but, if the second dose fail, it should be increased at once to a drachm, and the periods between the doses be entirely regulated by their effects. I do not regard chloroform as a cumulative medicine; I believe that it soon passes off by the lung, as the venous and charged blood is exposed to the air cells, and with it, its effects, leaving, however, in the case of delirium tremens, a sleep of a character that cannot be likened to the suspension of consciousness, which it causes when employed as an anæsthetic. In the latter case the brain is overpowered, and insensibility from blood poisoning produced, which lasts so long as the blood is sufficiently charged with the chloroform, and no longer. In delirium tremens, on the contrary, it is not the continuous circulation of the chloroform that produces continuous sleep. The impression temporarily made upon the brain, if sufficient, gives to that organ the power of regaining a certain portion of its *vis insita*, and thence ability to discharge its proper functions.

Sleep being the suspended function, and the one nature and the system demands, it exercises or rather comes under the influence of it, and if sufficient impression has been made by the chloroform, then the brain remains at rest until its normal tone is restored. Occasionally, it is true, we see genuine sleep follow upon the inhalation of chloroform, after insensibility has been produced, and the individual, instead of returning to consciousness, passes into sleep, although repose is not needed by the brain.

Such an instance is the following:—Not long since I was sounding a young gentleman who had symptoms of calculus in the bladder. He had inhaled chloroform moderately from a handkerchief, and came sufficiently under its influence in about two minutes to have the bladder (without consciousness) carefully explored. The examination ended, the sound was withdrawn, and I accompanied his father to a corner of the room to speak upon his case. I was engaged in conversation for some time, and then prepared to leave the house, but was called back in haste by his father, who said that his son was senseless. On returning to the room, I found the boy not as he supposed, but in a sound, comfortable sleep, from which he awoke in a natural manner, on hearing his father's voice.

Now until a calmative condition is produced, the chloroform already taken may, I believe, be considered as inert, and any good effect must be anticipated only from the succeeding dose. If this too fails, and delirium and excitement continue unchecked, then, after an interval of time sufficient to warrant belief that it also has been unappreciated by the system, the dose must be repeated, and so continued, and I regard an hour as the full period that need be permitted to elapse before it is again given. Certain I am that the strength of the patient will be more rapidly expended by the continuance of the disorder—its clammy exudation, its muscular activity, and mental horrors, being left unchecked—than by any sedative influence of the chloroform.

I have no fear of its use internally. I have employed it to a degree that may startle those who have not had much experience of it. I have, in a case of traumatic tetanus in the City of Dublin Hospital, kept a young man, aged 18, under its influence for nine days and nine nights successively, during which time he took a quarter of a pint by the mouth, and a pint and a quarter were evaporated closely over his nostrils, carrying him in a state of unconsciousness through this fearful disease, and restoring him to perfect health.*

I have lately, in a case of tetanic convulsion in an infant, only eight weeks old, in consultation with my colleague, Dr. Beatty, employed it even more largely still, for no less than five ounces of chloroform were expended in vapour in twenty-four hours, completely controlling the convulsions, the child dying solely from inability to swallow sufficient support.

With these facts, then, before us, and the experience of the happy effects of chloroform in treating delirium tremens, as already recorded in this and other journals, I think we should give it the fullest and fairest trial; for the "horrors" are, in a tropical climate, by no means the manageable disorder we see them here, oftentimes unyielding to opium, and frequently terminating in death; and any remedy holding out the hope of recovery, which chloroform does, should be, I maintain, most severely tested, before it is reported as *inert*.

RICHMOND HOSPITAL.

Clinical Lecture on Deep-seated Whitlow.

BY JOHN HAMILTON,

SURGEON TO THE HOSPITAL.

It is not often that we have an opportunity of ascertaining the pathology of deep-seated whitlow; I am therefore glad to be able to exhibit to you this finger, which I removed from the hand of John Phelan, No. 5 Ward.

Let me first read to you his case, as taken by Mr. Tyrrel.

John Phelan, æt. 40, a painter, was admitted into the Richmond Hospital, with mortification of the two last joints of the middle finger of the right hand, which were black, cold, and shrivelled, the consequence of deep-seated whitlow. The first phalanx, the neighbouring portion of the palm of the hand, and the back of the hand, particularly round the knuckles, were swollen and red, and there were three discharging openings, one on the front of the first phalanx, the second in the palm, and the third on the back of the hand, which had been made to let out the matter.

Ten days before he had a scratch on the back of the middle finger, and while immersing his hand in some size felt uncommon smarting in it: the next morning at four o'clock he was seized with a severe shiver and intense pain in the finger, which became swollen, with red lines remaining on the back of the hand from it. On the third day the top of the finger was quite black, and on the next day the blackness had extended to the base of the second phalanx.

On the fifth day, Mr. Hamilton saw him in consultation with Dr. M'Sweeny, and it was thought best to make a deep incision in the front of the first phalanx, which was very painful, red, and swollen; a quantity of matter gushed out with great relief, and he slept that night. It was necessary two days after to make the incision in the palm, and again that in the dorsum of the hand. These gave effectual relief to the pain, and the local inflammation became so much diminished, that Mr. Hamilton thought it fit to remove the finger at the metarcarpal articulation. Everything went on favourably, and he left the hospital 9th of December, the wound granulating and contracting rapidly, and his general health much improved.

The removed finger was carefully examined. The two last joints were black and shrivelled, and a faint line of separation was commencing between the dead and living parts. The first phalanx offered a good example of deep-seated paronychia in the advanced stage. The fibrous sheath of the tendon was very thick, the section white and firm, the lining membrane of a pink colour, and here and there bloodshot, with some deposits of flaky lymph. The flexor-profundus tendon was loose and soddened, and surrounded by pus. The periosteum separated from the bone by pus, and the bone dead. You will see here the contrast between this natural thin white sheath, with its smooth, pearly white lining membrane and glistening tendon, and the thick sheath of the whitlow finger with its rough, lymphy red inside, and its dull tendon smeared with pus.

Many of you will think this subject scarcely worth your attention; but you are wrong; for you will find deep-seated whitlow a very serious and painful disease, by which the use of the finger or hand may be destroyed, and which requires prompt treatment; and nothing but a thorough knowledge of its nature and progress will lead you to insist early on those measures, which, though apparently severe, will alone arrest its destructive progress. As you have just seen, deep-seated paronychia is an inflammation of the inside of the sheath of the flexor tendons of the fingers, rapidly running into suppuration. The symptoms are usually as follows: the affected finger becomes painful, the pain increasing to the greatest degree, so as to prevent sleep, and often to cause the patient to spend the night walking about his room in torture. This will be at first accompanied by little swelling and little redness, more especially in front, although the greatest suffering is complained of there. The finger will be kept bent, any attempt to straighten it increasing the pain, as does also pressure over the affected part. By keeping the finger flexed, the skin in front is relaxed, as well as the tendon, relieving the painful tension and the pressure of the tendon on the inside of the inflamed sheath. The back of the finger next becomes red, swollen, and shining, pitting on pressure. You might be misled by this, and think it was the place to make your incisions in search of matter, but it will be found that pressure on this part can be borne, whereas in front, where Boyer says this whitlow always occurs, it cannot; and when the finger is attempted to be straightened, the suffering is at once referred to the front. After the third or fourth day, this part will be found swollen and prominent, particularly on a side view, but no fluctuation is discernible. If no treatment is adopted, the disease will often proceed from the finger to the palm, which becomes red, swollen, and tender, the back of the hand particularly so, of a deep shining red, pitting on pressure, and fluctuation is soon apparent either over the knuckle of the affected finger, or in the web between the fingers. In the palm of the hand we often observe that the matter, after having made its way out through a small opening in the skin, does not pierce through the cuticle, which in the labouring classes is excessively thick, but separates it extensively, and you have a considerable collection of pus, only covered by cuticle, before you come to the real abscess; as the palm becomes engaged other fingers get flexed, and cannot bear extension, and the pain shoots up the arm to the shoulder; in a woman, I knew it extend to the breast of the affected side. In most instances the inflammation with suppuration stops at the finger and palm, particularly when treatment has been resorted to; but if not, it may go up the front of the wrist to the forearm, in which case the patient recovers after weeks of suffering, worn out by sleepless nights and profuse suppuration, with bent, emaciated fingers, and a stiff wrist, and a nearly useless hand. Should the disease not extend so high, or not be so violent, it may end with a stiff bent finger. I should say when there has been suppuration the finger is invariably stiff, and usually bent, from adhesion of the integuments to the sheath of the tendons, and of the tendons to the inside of the sheath, while in the state of flexion. If the inflammation is very intense, the tendons die and protrude through the natural or artificial opening that has let out the matter, and throw off greyish white sloughs; where a portion of the flexor profundus is totally destroyed, the finger may be quite straight, being kept so by the extensor tendon. Such is the case in the man now in the house, who came to the hospital after having suffered from whitlow six weeks. I took away a dead portion of the flexor tendon, one and a-half inch long, from the sheath. I am going to remove his finger, as he presents a further step in the disease, viz., the periosteum is stripped from the bone of the first phalanx by effusion of pus, and the bone is killed.

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* Case read before Surgical Society of Ireland, and reported in the *Dublin Medical Press* for February 8th, 1854.

The death of the bone is most common in the last phalanx, particularly of the thumb. In such a case you will find, though the matter has been let out by a free opening, the disease lingers, the part continues red and swollen, the opening discharges abundance of thin matter, and has large flabby granulations around it, and if you feel the end of the finger, there is a pseudo-fluctuating feel, as if it was extensively undermined; a probe passed in removes every doubt, by grating against the rough bone. It is best not to wait till it separates of itself, but enlarge the opening, and seizing the dead bone with a forceps, divide any ligamentous connexions at the joint, while any are on the stretch. The parts soon heal, the finger shortened, bent forward, and clubbed at the end, the nail irregular, but still a useful finger. In one of the coachmen in Mr. Champion's establishment, in whom the disease had been very violent for three months before I saw him, I found through a long side incision, which had been made by a surgeon, the first and second phalanges dead and bare of periosteum, and the third projected through a sloughy opening at the end of the finger; though the bone was dead, the soft parts were alive. In other cases both mortify, and the whole or part of the finger becomes cold, black, and shrivelled, as in Phelan's case, and also in a woman in Mr. Adams' ward, now in the hospital. Last season I had to remove a finger, for this cause, from a woman in whom it had mortified a few days after the disease began. Indeed, I have had to perform the same operation frequently, the cases being those in which the inflammation had been most acute, and the early treatment neglected. The excessive and rapid effusion into the sheath, and the attendant sudden swelling before the parts can accommodate themselves to it, seems to produce a strangulation, the circulation is arrested in the vessels, and the parts die.

The fever, in deep-seated whitlow, often runs high, and I have known delirium at night, but I never met with a fatal termination except in one case, a man who crushed his thumb while intoxicated; deep-seated paronychia followed, inflammation of the veins up the arm, and death.

On looking over the notes of many cases, I find the most frequent seat of deep-seated whitlows to be the middle finger, next the ring, and then the index finger, all before the thumb. This agrees with Boyer's experience; it differs from what we perceive in the superficial paronychia, in which the index finger and the thumb are so much the oftenest affected, and at their extremities. The part of the finger in the deep-seated paronychia most commonly engaged is the sheath of the flexor tendon over the first phalanx; this sheath is not only the longest, but the strongest and most complete. Men are more frequently affected than women, and the disease is most prevalent in winter. A few cases, when suppuration was threatened, subside and terminate by resolution. The majority run rapidly into suppuration, which is more or less extensive, according to the intensity of the inflammation. Such is an outline of the symptoms and pathology of deep-seated whitlow. You see that it is an inflammation of the inside of the sheath of the tendons, that nature makes vain efforts to get out the matter confined in the strong fibrous envelope; you have witnessed the diastrous effects of the unrelieved diseased action, the periosteum, the tendon, the bone, all at last engaged, and the finger, or even the hand, permanently injured or even lost. You will at once naturally arrive at the conclusion, that a free incision into the sheath, early performed, is the only treatment. Yet how is it that so many cases come to the hospital, where this has never been done, and all the destructive consequences allowed without an incision ever having been made.

I believe it arises from timidity, a fear of wounding blood-vessels, particularly when the disease approaches the palm; there the palmar arch becomes a kind of bugbear. Some years ago, I made careful dissections of the hand, with a view of furnishing myself with precise rules for making incisions in deep-seated whitlows. Permit me to call your attention to a few practical conclusions I arrived at:—

There are two principal wrinkles or lines running across the palm of the hand; one, nearly transverse, corresponds to the joints between the metacarpal bones and first phalanges, and is situated about an inch behind the first transverse lines on the fingers. The second begins from the first, at the articulation of the index phalanx with its corresponding metacarpal bone, and goes in an oblique direction across the palm towards the pisiform bone at the inside of the wrist; *it answers pretty nearly to the course of the ulnar or superficial palmar arch.* These two lines, which are very regular, will be found to serve as excellent guides in making our incisions in paronychia with confidence.

On the fingers there are three bundles of transverse lines; the two from the tip correspond to the articulations, that next the palm does not correspond to any joint, but is situated about the centre of the first phalanx and of the sheath of the flexor tendon.

The palmar fascia goes about as far as the transverse palmar line before it sends off its four processes which go between the fingers, and are attached to their sides along with the tendinous insertions of the extensor muscles and the lumbricales.

The web between the fingers contains the digital artery from the palmar arch and its division, and is filled up with loose cellular tissue, allowing matter easily to go from the palm to the back of the hand. As the superficial palmar arch, the only one likely to be wounded, corresponds to the oblique line which is behind the transverse line, the distance increasing as it approaches the inside of the wrist, you can, in all the fingers, *safely* make your incisions as far as the transverse line; nay, in all fingers but the middle, you can cut beyond this as far as the centre of the hand, and in the index finger even further. But it is worse than useless ever to carry your incision from the finger further than the transverse line, so as to endanger the arterial arch at all, as after going so far it is quite sufficient to pass a director under the palmar fascia, which alone confines the matter, if it has gone into the hand. On the director, you could, if desirable, cut out through the fascia and even the annular ligament. Whereas if you cut down without a director to the palm, through all the parts to the bone (which in the palm is unnecessary, as there is nothing below the palmar fascia or annular ligament to confine matter), you could scarcely avoid wounding the arteries or large nerves. In the same way in the fingers after the sheaths of the tendons are divided, nothing remains to confine matter. These sheaths extend from the tip of the fingers to the transverse palmar line or metacarpal phalangeal articulation; they are thick and strong between the joints, thin opposite to them; you should avoid over the joints, and confine your incisions to the strong part of the sheaths between them, cutting to the bone if you choose, or what is generally enough, down to the tendon, taking care to open the sheath well, and always keeping in the centre to avoid the digital arteries running along the sides of the fingers. In the thumb it is particularly necessary to observe this last rule, as, otherwise, after cutting beyond the first joints you would be very likely to wound the superficialis volæ.

Bearing these facts in mind, you will have no hesitation in making sufficiently free and deep incisions. I repeat, take care that your cut is long enough to open the sheath freely; a mere deep puncture through it may let out matter, and give ease for the time; but not allowing free vent, will cause the pus to seek another outlet, and much mischief ensue. Three weeks ago, the Rev. Mr. Crampton's coachman came to me, suffering dreadfully from deep-seated whitlow in the sheath of the tendon of the first phalanx of the middle finger of the left hand. I plunged in a sharp, straight bistoury, and laid open, by continuing the incision, at least one-half of the sheath; a quantity of thick matter gushed out, and he never had any more trouble from the finger. You are not always so successful; in spite of free incisions the diseased action is not stopped. In such cases, though there is at first much relief, the unpleasant sensations return, the next night the patient will be kept awake by deep-seated throbbing pain, and you may be sure that the matter is working its way out in some other direction, and is not getting free exit, and you will probably discover some swollen, tender spot, to repeat your incision. If the disease presents itself in a more advanced and aggravated form, not only engaging the finger, but extending to the palm, back of the hand, or even the wrist, which last is very rare, you will have to follow the matter, regulating your incisions by the rules I have mentioned to you. Some authors have made a separate division of paronychia, which they name paronychia periostei, from supposing the disease in this form to commence in the periosteum covering some part of the phalanges, with suppuration between the periosteum and bone, death of the bone, &c. I regard the affection of the periosteum rather as a secondary effect of the deep-seated paronychia, whose seat we have seen to be the sheaths of the tendons, but when neglected, to engage finally, all the tissues, the periosteum among the rest, and the bone. When the first or second phalanges are stripped of periosteum, and dead, it is best to remove the whole finger at the metacarpal articulation, as I am going to do with the man in the house, who has only the first phalanx bare and dead. If it is the last phalanx, it can be removed alone, and as I have already said, a useful finger will remain after the opening is healed.

Case of Impacted Renal Calculus, with complete Destruction of the Glandular Structure of the Kidney, and its Conversion into a large Multilocular Abscess, with Deposits of a Gelatiniform Matter.

BY B. WILLS RICHARDSON, F.R.C.S.I.

At a recent meeting of the Dublin Pathological Society (3rd inst.), I laid before the members an interesting specimen of calculus impacted in the pelvis of the left kidney, and producing by its presence there destructive inflammation of the glandular structure of the organ, and its conversion into a large multilocular abscess.

The patient, Daniel O'Connell, æt. 42, was admitted into the hospital of the North Dublin Union Workhouse, under Dr. Kirkpatrick. He was at that time (14th February, 1854) in a very emaciated, cachectic condition, suffering from excruciating pain in the left lumbar region, and passing urine which deposited a considerable quantity of pus. Some time previous to this he passed by the urethra a few small renal calculi. Dr. Kirkpatrick, on examining the seat of the pain, distinctly felt, through the abdominal parietes, a large, oblong, hard, and excessively tender tumour, occupying the situation of the left kidney. The treatment consisted in good diet and a mixture of infus. buchu, tinct. ferri. muriat. and tinct. opii. When he had been under this treatment for some time, the urine altogether ceased to deposit pus, and he became so improved as to entertain sanguine hopes of recovery. He continued in this improved state for four months, but the tumour remained without any perceptible alteration. About a month before his death he was attacked with diarrhœa and nausea, and in a fortnight afterwards his bladder became excessively irritable, accompanied by some difficulty in micturition, and the pus reappeared in the urine. Purpuric spots made their appearance on different parts of the body; he went from bad to worse, vomited occasionally, and died on the 31st of last month. Two appearances attracted my notice when I opened the abdomen, the day after his death: one was the small intestines dotted over with petechiæ; and the other a large oblong tumour filling the left lumbar region, and having the descending colon adherent to its anterior surface. I found great difficulty in removing the tumour, owing to its firm attachments; it was about the size of a large beef kidney, smooth on the surface, and excessively tense. On opening it longitudinally, it was found to be the left kidney transformed into a large multilocular abscess, containing a great quantity of pus, having a most sickening odour. No traces of the glandular structure of the organ were to be seen, but its pelvis was completely filled by a large calculus, and at each end of the pelvis there was a pretty large deposit of a gelatinous, colloid-looking matter, in which could be seen ramifying a number of fine whitish bands or lines. Under the microscope this substance did not present the character of true colloid; and Dr. Lyons, who subsequently examined it, is of the same opinion. I have never, however, before seen any morbid structure, which to the unaided eye so much resembled areolar cancer.

The ureter was pervious throughout its whole course.

The right kidney was about one-half larger than usual, but its structure was healthy, with the exception of some unusual vascularity of its pelvis. It is evident that its increased size was the result of a compensatory process, by which it was enabled to make up to the system for the destruction of its fellow.

The bladder was not larger than usual, its lining membrane was inflamed, but not ulcerated, and at the trigone it was of a greenish colour. The prostate was slightly enlarged, and its middle lobe projected sufficiently to prevent the urine which was in the bladder escaping until the latter was opened.

The most interesting feature in this case is the fact, that for four months the urine ceased to deposit pus, although the disease in the kidney must have been progressing. I can only explain its disappearance in the following manner:—That at the time of the patient's admission, and up to the period of the cessation of the purulent deposit, one of the abscesses was discharging its contents into the ureter, and that the colloid looking deposit, or, perhaps, the calculus itself increasing in size from the continual deposition of triple phosphates on its surface, at last obliterated either the abscess, or the opening by which it communicated with the ureter. Things remained in this state until a short time before death, when ulceration established a new passage for the pus into the ureter, and through it to the bladder.

The absence of vomiting, with such an amount of disease of the kidney, until a short time before death, is also remarkable, as well as the total absence of head symptoms; but I should think the latter may be explained by the integrity and activity of the right kidney, enabling it to remove the poisonous matters which the left was unable to excrete.

Suppuration of the kidney, with impacted renal calculus, does not necessarily imply either a rapid disease or a fatal result, a great deal depending upon the situation of the calculus in the kidney, and the amount of obstruction it may occasion, as well as the constitutional powers of the patient; nature often, in such cases, making great and successful efforts, not only to get rid of the calculus, but also to prolong life, or ultimately effect a cure. For instance, Sir B. Brodie* mentions the case of a lady, whose urine deposited pus for two or three years, when she was attacked with symptoms of the passage of a calculus along the ureter. A renal calculus (oxalate of lime) came away, and the painful vesical symptoms under which she had laboured were relieved. Pus continued in the urine, however, in small quantities afterwards. But, in a paper by M. Lafitte, in the Memoirs of the French Academy of Surgery,† we have more striking instances of the powers of nature in cases of renal calculus.

A tumour formed in the left lumbar region of a woman of 35 years of age, accompanied by fever and diarrhœa. It was preceded by pains, which extended from the kidneys to the upper part of the back. A deep fluctuation was felt in the tumour. After five or six days the fluctuation became more sensible, and M. Lafitte opened the abscess. A good deal of pus, having different colours, escaped. After fifteen days the fever had ceased, but on the twenty-second day she was again attacked with fever and a pulsative pain in the wound. On removing the dressings they were found to be saturated with pus, and large quantities of this fluid subsequently came away. In consultation with M. Jallet, it was agreed to sound the sinus, when they felt a hard body, such as a stone would be. The next day MM. Jallet, Bimont, and Fagit also saw the case. It was now resolved to extract the hard body, which turned out to be a calculus, the size of a filbert. On reintroducing the finger into the wound, another calculus was felt, which was also removed; it was the size of a nut. A great quantity of pus, having the characters above mentioned, now came away. Pus was not observed in the urine, which renders it evident that the sac which contained the calculi did not communicate with the pelvis of the kidney. The suppuration gradually diminished, the abscess healed, and the patient perfectly recovered.

In another case, a patient of M. Sauré, a young man of 25 years of age, a tumour the size of an egg formed in the right lumbar region. It was preceded by pains in the kidneys, like those of nephritis. After some days the tumour apparently quitted its first situation and appeared in the upper part of the iliac region of the same side. Caustic was applied to it, but this was followed by great constitutional disturbance. Having been advised by M. Boudon, M. Sauré made an opening through the eschar, and gave exit to a large quantity of pus. The wound degenerated into a fistula.

At the end of eleven years M. Lafitte saw this patient. On examining the sinus he discovered a hard body, with a sound, which he removed on the following day. It was a calculus having the shape of a mamillary process of the kidney. The wound, however, remained fistulous, which Lafitte attributed to another stone being in the kidney.

I shall conclude with the third case. It was that of M. La Batte. He, in 1741, had an abscess in the lumbar region, which was opened, but the opening remained fistulous. In 1747 he went to Paris, and consulted Petit and Le Dran. They sounded the fistula, but they did not perceive the stone, and they advised La Batte to keep the sinus open with bougies. He returned to Pau, and at the end of eighteen months a calculus, the size of the second phalanx of the little finger, escaped from the fistula.

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* Diseases of the Urinary Organs, page 236. 1842.

† Tome 5, page 188. 1787.

It is only in cases like the above, when an abscess forms or points in the lumbar region, that the extraction of a renal calculus from the kidney is practicable. Nature, as Lafitte observes, must show the surgeon the course he should pursue.

PATHOLOGICAL SOCIETY MEETINGS.

January 13, 1855.

DR. ADAMS IN THE CHAIR.

Gangrenous Abscess of the Lung.

DR. HUGHES exhibited a gangrenous abscess of the lung, with a drawing. He remarked that the history of the case presented some features of interest, and he had no doubt of its correctness, as it was obtained from the patient while in hospital, and from his wife after his death, the accounts of both coinciding in all material points.

Reported by MR. CONSTABLE, *Resident Pupil.*

Patrick Byrne, aged 38 (a labourer), was admitted into the Medical Wards of Jervis-street Hospital, 5th Dec., 1854. He presented a condition of extreme debility and prostration. His countenance expressed much anxiety, and indicated the presence of some organic disease. The skin was of a yellowish tinge, and felt burning hot and dry; the pulse was 100, and excessively feeble; breathing 32 in minute, but not oppressed; urine scanty, and depositing the lithates; appetite completely gone; bowels confined; tongue moist and clean. He lies altogether on the left side. He has frequent and harassing cough, with purulent expectoration, which emits a gangrenous odour, as does also the breath; the expectorated matter is of a brownish colour; the patient is quite aware of the fœtor, and says it sickens his stomach, and prevents him eating, as he finds no taste from any kind of food. He had no pain in the chest, and there was no œdema of any part of the body; but he was wasted to the last degree.

The physical examination displayed well-marked flattening of *the right side*, from the mamma downwards; deepening of the intercostal spaces, and a measurement of one inch less in circumference than the opposite side. The sound on percussion was dull all over that side, anteriorly and laterally, and there was tenderness in the infra-mammary region. The *left* side was comparatively, though not normally, clear. The posterior surface of the chest sounded equally clear on both sides.

The principal stethoscopic signs were cavernous breathing, with large mucous ralè over a space, about two inches in diameter, in the left infra-mammary region, and around this spot diffused bronchial respiration. On the opposite side the breathing was rough, but not accompanied by any ralè. There was well marked resonance of the voice on the right side.

The account he gave of his illness was, that it commenced eleven months ago with cough and some slight spitting of blood after exposure to cold: the cough, after a week, was accompanied by bad breath and expectoration, and an attack of hæmoptysis.

He was admitted into the Rathdrum Hospital, where he remained for a week, until the hæmoptysis ceased, and then returned home. For two months he was unable to work; but *the fœtor of breath had disappeared*, the expectoration was trifling, and the hæmoptysis had ceased: the cough alone remained. Finding himself so much better, he resumed his usual work; and in August cut down several acres of meadow, a work requiring more than usual exertion. During November he threshed corn (another laborious occupation), and continued at it until three weeks previous to his admission. He caught fresh cold then; his cough increased, the expectoration became stained with blood, and again so *extremely fœtid* that his stomach often sickened and rejected its contents. After lying at home without any relief for more than a fortnight, he came to town, and walked twelve miles of the journey on the day he arrived. He states that, up to the commencement of his present illness, he enjoyed ordinary health. But his condition in life was very poor; he was badly clothed, badly fed, seldom or never tasting animal food, and continually exposed to cold and damp.

The progress of his disease while in the hospital was rapid, and, I may say, unchecked; for a little time the extreme fœtor was lessened by the exhibition of chloride of soda, and the sputa were almost without smell for some days. But the change was only temporary; the fœtor again increased, and induced vomiting, with a distaste for all food. Profuse perspirations occurred almost every night, and he sank in three weeks after being received into the hospital, and six weeks from the commencement of the present attack.

Post Mortem Examination.—On opening into the thorax, we found adhesions at the right side, especially between the lower lobe of the lung and the parietes—the left lung was free. An enormous abscess occupied the lower, and a considerable portion of the middle lobe of the right lung; it came nearest to the surface anteriorly, where it was bounded merely by the pleura, and it burrowed downwards and backwards, so as to approach very nearly to the diaphragm. None of its contents, however, escaped into the pleural cavity. The abscess measured more than six inches from above downwards, and might readily contain from eight to ten ounces of fluid; it contained a greyish-coloured pus, mixed with the broken-down lung, and a blackish slough lay at the bottom; it was traversed by bands, and communicated with another but smaller cavity in the direction of the posterior surface of the lung. The abscess was surrounded by condensed lung in the second and third stages of pneumonic inflammation. The apices of both lungs were of a bright vermilion colour, and presented that condition which Dr. Stokes describes as the first stage of pneumonia. The left lung contained a small abscess (about the size of a nut) at the base of the superior lobe, and there were some minute granules, like nascent tubercles, thinly scattered through that portion of the lung. No tubercles were found in the right lung.

The case just recorded appears to be one of chronic or unresolved pneumonia, ending in gangrene: The disappearance of the fœtor in the early part of the case, and the apparent recovery of the man so as to enable him to resume his laborious occupations, together with its quick return with the second attack, are interesting facts; and the latter shows us very strikingly how quickly inflammation is disposed to assume an unhealthy form, when the system is lowered by privation and want.

The formation of the cavity was extremely rapid, for when this patient came into the hospital, the physical signs of an abscess were not at all well pronounced, and at no time were they discoverable over a space of more than two inches in diameter. In fact, the constitutional disturbance and suffering were infinitely greater than the physical signs could account for, and it required the presence of a septic poison to produce them. The purulent deposit in the left lung was the result of pus having entered the circulation, as there was no surrounding inflammation. The tubercles were recently deposited. It is remarkable, that no perforation of the lung occurred, although the wall of the abscess was so very thin, and it approached so near to the surface. Such an accident is, I believe, very rare, but I have seen it occur with pneumothorax (in a patient who was under my care in the hospital two years ago), as the result of a pneumonia of five weeks' standing; and Dr. M'Dowel has lately exhited another similar case.

EVENING MEETING OF THE DUBLIN PATHOLOGICAL SOCIETY.

February 29th, 1855.

DR. LAW IN THE CHAIR.

DR. ROBERT M'DONNELL read a paper on the Elective Secretion of Glands, and the physiological Causes of Albuminuria.

GENTLEMEN,—During the past summer I occupied myself in a series of experimental researches in physiology, with the view of refuting some novel theories set forth by the celebrated French physiologist, Claude Bernard; the results of these experiments I made public in the Glasgow Medical Journal of last October, and with them some of those present are acquainted.

When engaged in these investigations, I was naturally led on to perform some experiments, which bore but indirectly on the subject I had then before me, and some of these (which I have not before brought forward) I wish to lay before you this evening. I do not, however, wish to have it understood that I lay claim to much originality for my experiments; most of them are mere repetitions of those already performed by others, but as I consider that some merit is due to the person who, by repeating such experiments, either proves the truth of or falsifies the observations of others, I feel assured that it will not be found uninteresting for me to communicate the results of my researches.

I shall first detail some experiments to prove the elective power of glands in *choosing*, as it were, certain matters for elimination from the blood; first observing that merely to prove this fact (were the investigations confined to that), no experiments would have been necessary, for it is a self-evident fact, that while the same fluid, in the course of its rapid circulation, pervades all glands and tissues equally, each has a so-called elective power of selecting for itself some of its ingredients, and leaving others; as will appear, the following experiments are of importance in another point of view, and one of high practical interest.

The *First Experiment* was on a full grown and healthy rabbit. I injected into a vein in the animal's neck nearly one drachm of a solution containing equal parts of iodide of potassium and yellow prussiate of potash. I placed the animal in a small wire cage set slanting, and before I had time to get a vessel to collect the urine, that is, in less than five minutes after the operation, the animal passed water, some of which I sucked up in a glass syringe, and found to contain the yellow prussiate abundantly, but no iodide; after half an hour I had more than one ounce of urine collected in the cup, but could barely detect the iodide, although the prussiate was very abundant. I left the animal for the night; next day both salts were easily detected in the urine passed during the night.

Second Experiment on a middle sized dog, strong and in good health. I injected into a superficial vein at root of the ear a similar solution to that used in the last experiment, viz., iodide of potassium and yellow prussiate of potash, equal parts. In a few minutes the first was detected in the saliva, and the second in the urine, but no iodide of potassium appeared in the urine for more than an hour, and no yellow prussiate of potash ever appeared in the saliva. I may here add that I chose a dog for this experiment, because it is very difficult, I might say impossible, to collect the saliva of a rabbit; but on the other hand, the rabbit is much better for urinary experiments, since pressure above the pubes generally has the effect of expressing some of the desired liquid.

Third Experiment.—I myself swallowed a solution containing equal parts of yellow prussiate of potass and iodide of potassium (30 grains of each). In a very few minutes I perceived the peculiar taste of the latter salt in my mouth, and in ten minutes I detected it in the saliva, by tests; at the same time the prussiate was to be found in the urine (by the addition of acetate of iron, and a few drops of nitric acid), but till a later period the iodide did not appear in the urine; after an hour both salts were abundant in the urine; the prussiate never made its appearance in the saliva. The iodide continued to be detectable in the saliva, and the prussiate in the urine for several days.

In these experiments, we have two different salts introduced into the blood, either by direct injection, or by absorption. These being received into and entering the torrent of the circulation, they, with amazing rapidity, pervade the whole system, and are, of course, equally offered by the circulating fluid to each of those glands, the secretions of which were chosen for examination. We find, however, that the salivary gland, although both are offered, chooses but one for elimination; that which it does choose (the iodide of potassium), it lays hold of very promptly, and eliminates with great activity; the other it takes no more notice of than if it were not in the system at all. The conduct of the kidney is more striking still; both salts are likewise offered to it at the same moment, and in the same quantity; it first chooses the prussiate, and later, the iodide.

The yellow prussiate of potash is sent forth from the system with comparative rapidity. The iodide sojourns longer, and for this obvious reason, that through the medium of the saliva it continually returns to the stomach, being excreted to be reabsorbed; it is important to remember, that its sojourn in the system may be made much shorter by the use of purgatives, as may also be, in all probability, the sojourn of more deleterious, though less easily detected morbid matters.

There is good reason to believe, that materials may exist in the animal economy, in such a state as to be unfit to be thus chosen by a gland (the kidney suppose) for elimination; but, by the introduction of some other ingredient, it may be put in the predicament of being suited for selection, and thus got rid of. Thus, iodide of potassium seems to promote the elimination of lead and other metals.

Dr. O'Ferrall has lately published a case in The Dublin Hospital Gazette, in which lead colic was cured by iodide of potassium. The absence of lead in the urine was ascertained, he says, before the treatment was begun, but unfortunately, the urine was not afterwards analysed.

The cases treated by Dr. Swift, in the New-York Hospital, offer more satisfactory results. Twenty-three cases were treated; in thirteen instances the urine was submitted to chemical analysis, and the investigation has established the fact, that lead may be eliminated from the system, by the aid of iodide of potassium, and found in the urine. In no case could the lead be detected before the administration of the remedy.

In a physiological point of view, some cases lately detailed by M. Malherbe, Physician to the Hotel Dieu, of Nantes, are yet more interesting.

"The elimination of lead," he says, "under the influence of iodine being admitted, it remains for us to seek out in what way it takes place. The facts reported by M. C. Bernard, relative to iodide of potassium, led me to examine the urine, the saliva, and the sweat. We have not, however, deemed it necessary to test this latter secretion, for independent of the difficulty of collecting a sufficient quantity of it, the skin of patients suffering from lead poisoning is in general sprinkled over with particles of lead in some form."

He details four cases accurately noted, and observes that although these experiments are not sufficiently numerous to establish definite conclusions, yet that they would induce one to believe—

First—that in "saturnine intoxication the lead is naturally eliminated by the urine, probably under the influence of the alcaline chlorides contained in this secretion; but this elimination takes place so slowly that it is not sufficient to produce a spontaneous cure of the diseases caused by lead."*

Second.—"Under the influence of iodide of potassium, the elimination of lead in the urine becomes much more active, but at the same time the elimination of the phosphates is considerably increased, and these salts give, on evaporation, a solid residue, which retains a great part of the lead eliminated with it."

Third.—"Lead is not naturally eliminated in the saliva, but iodide of potassium is capable of causing its elimination through this channel."

The abundance of phosphates observed in the urine of persons using iodide of potassium may, in some degree, explain the efficacy of this medicine in rheumatism, gout, &c.

Possibly the good effect of iodide of potassium in other cases of metallic poisoning may be similarly explained as in the cases of slow copper poisoning, reported by Dr. Corrigan, and so successfully treated by this agent, and it is a question worthy of consideration whether the beneficial influence of this remedy, in the treatment of secondary syphilis, may not be in some degree owing to its antimercurial as well as its antivenereal properties.

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* From this it will be understood that M. Malherbe in his cases detected traces of lead in the urine before the administration of the iodide.

The second series of experiments which I wish to bring before you, were undertaken with a view to show what conditions of the circulating fluid are accompanied by albuminuria, without necessary organic disease of the kidney. I would observe that I do not use the word albuminuria to denote a disease; I regard it as a symptom, no doubt a most important one, yet one common to many and various diseases of the kidney, just as cough is to many of the chest. I use the term, therefore, as indicating an abnormal condition of the urine, and I undertook the experiments, which I am presently about to detail, to show how far that abnormal condition depended on the circulating fluid.

The diseases attended with a flowing off of albumen in the urine may be divided into two classes:

First.—Those not dependent on structural disease of the kidney, but on either a derangement of its normal secretive function, or a morbid condition of the blood.

Second.—Those dependent on organic diseases or mechanical obstructions to the flow of venous blood from the kidney, as for instance is said to be produced sometimes by the gravid uterus.

That the origin of kidney disease is often dependent on causes not localized in the organ itself, but affecting the system generally, is certain, and of this we have great proof in the fact to which I have more than once heard Dr. M'Dowel call the attention of this society, viz., the symmetry so usually observed in the commonest chronic renal disease, as well as its association with analogous diseases of other organs, showing that the starting point of the disease is in something equally affecting both glands, as a blood disease would, or anything causing an impeded flow of blood in the ascending cava, thereby bringing about congestion of both kidneys equally.

On the table are a variety of injected microscopic preparations, illustrative of the minute anatomy of the kidney in man and other mammalia. Most of them are my own handiwork; some made by Professor Hyrtl, of Vienna, are of exquisite beauty; to one of these latter I wish to direct especial attention, for in it an injection thrown into the pelvis of the kidney has passed backwards along the uriniferous tubes, "usque in capsulas Malpighianas," as is written on it by Professor Hyrtl himself.

These preparations prove the correctness of Mr. Bowman's views with regard to the renal circulation, viz., that the cortical substance is composed, for the most part, of tortuous uriniferous tubes, ending in flask-shaped extremities. Into this extremity there passes a small artery, which immediately divides into a tuft of vessels, which re-uniting form a small vein, which comes out of the flask close to where the artery entered it; on coming out, however, it does not join similar ones from elsewhere, but like an artery, or rather like the vena porta on entering the liver, it forthwith divides into small venous capillaries, which form a network on the sides of the uriniferous tubes, and ultimately uniting, go to form the emulgent vein.

First Experiment.—I collected the urine of a large, strong, healthy rabbit passed during twenty-four hours; there was much phosphatic sediment; on being filtered it measured four ounces, was of sp. gr. 10·20, slightly alcaline, became turbid from phosphates on being heated, but cleared with nitric acid; it contained 2·5 grs. urea to the ounce, was free from sugar and albumen.

I injected half an ounce of a strong filtered solution of white of egg and water into the cellular tissue on the back of this rabbit; I again confined him for twenty-four hours; he passed in this time five ounces of urine, sp. gr. 10·22; it contained urea, but I did not estimate the quantity; it contained albumen, but not abundantly.

Second Experiment.—On the same rabbit, after ten days, the urine having resumed its normal condition, I injected into the cellular tissue, about the shoulder, as much serum as I could obtain from the blood of another rabbit which I had just killed; next day I detected slight traces of albumen in the urine.

In the latter experiment the animal was in some degree in the predicament of a person having simple anasarca. The serum of blood was diffused through the cellular tissue of its body, and this caused albuminuria. It is a question whether this state of things, if maintained for a length of time, would give rise to renal disease.

I examined, when resident pupil in the Whitworth Hospital, the urine of seven patients, all in the hospital at the same time, having pleuritis with effusion; five of the seven gave traces of albumen; yet, it is certain, in the human subject, the simple existence of œdema in the cellular tissue of the body does not cause albuminuria.

Third Experiment.—I injected ʒi. of a strong solution of white of egg in water into the subcutaneous cellular tissue on the back of a young rabbit, nearly full grown; in a second I threw the same quantity into the jugular vein; and in a third into a branch of the vena porta. In the first two, evident though slight traces of albuminuria occurred, but no albumen appeared in the urine of the third; thus proving, according to

Bernard, to whom we are indebted for this remarkable discovery, that albumen, in its passage through the liver, undergoes some process of assimilation which fits it for retention in the system; whereas, if introduced directly into the circulating fluid, it is not suited for being retained, and is consequently eliminated.

It is stated that the use of mercury causes albuminuria; but after repeated examinations of the urine of persons labouring under salivation, I have come to the conclusion that the statement is not well-founded, nor does the prolonged use of mercury seem to induce renal disease,* any more than it does many other affections, which are, of course, more liable to occur in constitutions injured by this debilitating influence.

A dog was rubbed all over with mercurial ointment to cure him of mange; he licked it off and became poisoned by mercury; he refused all food—would drink nothing but water, and that in immense quantities; the urine was scanty, high-coloured, but at no time albuminous; in nine days from the inunction he died; there was extensive ulceration of the large intestine, ceasing abruptly at the ileum; no ulceration of the small intestine or stomach; no sign of disease of the kidneys or bladder.

Among other causes of albuminuria is the respiration of arseniuretted hydrogen; it seems that this gas so acts on the blood as to permit of its albumen being excreted, and it, no doubt, may be owing to similar influences that albuminuria occurs, as it sometimes does, in typhus and low fevers.

Great dilution of the blood with water, according to Kierulf, is attended with passing off of albumen by the urine. Dr. Owen Rees† states a fact which I have more than once verified, that in persons who die slowly, albuminous urine is found in the bladder after death, although the kidneys are apparently healthy; because as the vital power is slowly sinking and becoming extinct, the fluid part of the blood transudes mechanically and becomes mixed with the urine.

These facts are significant, and their importance as to the origin of renal disease is sufficiently obvious. I had intended to detail this evening another series of experiments relating to urea and sugar elimination, but I have already occupied too much time, and conclude by acknowledging the great assistance which I have derived in those cases where I wished to estimate the amount of urea in the urine, from the plan and instrument proposed by Dr. E. Davy. His discovery must be regarded by those interested in this subject as one of the most important which chemistry has, for a considerable time, given to Practical Medicine.

After the reading of Dr. M'Donnell's paper, some interesting discussion followed, in which the Chairman, Drs. Stokes, Lyons, and Collis took part.

SUMMARY.

The Therapeutic Action of Lupulin.—By Zambaco.—Debout's observation on the favourable influence of lupulin in quieting painful erections induced the author to institute some experiments with the medicine, which, to prevent mistakes, he administered to the patients with his own hands. The form was threefold; pure lupulin, the tincture, or mixed with an equal part of sugar. The doses were different: of pure lupulin, 1—16 scruples (these high doses caused no disturbance of the nervous system); the tincture, 2—16; the mixture with sugar, 2—3. From eight well-marked cases of painful erection, consequent on gonorrhœa, out of a much larger number, the author was enabled to draw the following conclusions:—Lupulin possesses a remarkable effect upon the genital organs; the erethisms were quieted in four-fifths of the cases. It is of therapeutic utility when there exists the necessity for keeping the penis in a state of rest. Camphor given in large doses, with a similar object, both irritates the alimentary canal, and often fails in its end. The sedative and anti-blenorrhagic influence of lupulin depends upon a resinous, æthero-oily principle; while the bitter principle yields a real tonic. The author has seen lupulin given with good effect in scrofula.—*Bull. de Ther.* (from *Schmidt's Jrbuch.*)

On the Systematic Removal of the four permanent First Molars at an early Period, in a large Majority of Cases, when incipient Caries is present. By Samuel Maclean, Esq.—This mode of treatment is not new. It was recommended by Mr. Fox in 1803, and is supported by the author, although it has not received general support. The advantages are:—

1. The prevention and correction of the simpler forms of irregularities in the easiest and most desirable way, in a great majority of cases, without the aid of mechanical means; in all, in such a manner as least to disfigure the appearance of the mouth.

2. The promotion of a healthier state amongst the remaining teeth; the prevention (probably) of caries, certainly an increase in the facility of treating it.

3. The prevention of the distressing, in some cases even very serious, symptoms which frequently accompany the development of the wisdom teeth in corroded arches, and a material diminution in the chance of the formation of sinuses in after-life.

These statements were supported by cases, illustrated by numerous accurately-executed casts. The author also exhibited forceps of a novel construction, by which he was enabled to remove carious teeth. Each instrument consisted of a pair of narrow forceps sliding over one another, so as to be able to grasp the tooth in two different levels.—*Lancet.*

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* Dr. Owen Rees on the Nature and Treatment of Morbus Brightii, p. 27.

† Ibid. p. 28.

Cod-liver Oil with Quina.—Mr. Bastick gives the following account of his mode of preparing this medicine:—The oleum morrhua cum quinâ is simply a perfect solution of quinine in cod-liver oil. The quantity of quinine may be varied according to the wish of the prescriber, although it is generally employed in the proportion of two grains to each ounce of the oil. This preparation is best made in the following manner: The requisite quantity of disulphate of quinine is dissolved in distilled water, with the aid of a little dilute of sulphuric acid. The quinine is precipitated from its solution by means of an alkaline carbonate; the precipitate is treated with boiling alcohol; the resulting alcoholic solution, after being filtered, is evaporated to dryness. The residue, which is pure quinine, is then added to the cod-liver oil, and the mixture is heated in a water-bath until solution is completely effected, which is known by the oil becoming perfectly transparent.—*Lancet.*

Professor Forget on the Non-identity of Typhous and Typhoid Fever.—Although typhous and typhoid fevers resemble each other very much in their external appearances, Professor Forget of Strasburg believes that they are clinically and essentially different in their nature. They are anatomically different; they are not equally frequent in their occurrence; and typhoid fever may arise from many causes, quite irrespective of infection. In follicular enteritis, the typhoid condition is not constantly present, and it is usually secondary; while in typhus, the prostration and stupor, attending its invasion, indicate a powerful intoxicating principle, acting primarily as a poison, which is not usual at the commencement of the typhoid state. Gastro-intestinal symptoms are more constant, and primitive in typhoid than in typhus fever; for in it they are occasionally found existing alone; and we very rarely see cases of follicular enteritis which do not present the rough (*saburral*), punctulated, and rosy tongue; also *gargouillement* and pain in the right iliac region, and either diarrhœa or constipation. Though other symptoms may coexist with them, they are never wholly obscured. In typhus again, especially at its outset, the tongue is frequently moist, smooth, and white; meteorism and abdominal pain are absent, and there is no derangement of the process of defæcation. If we except the rosy, lenticular spots, peculiar to typhoid fever, and which constitute, according to M. Forget, its most constant differential sign, there are no symptoms in general connected with either malady which are not purely accessary and inconstant. Typhoid fever is usually slow, and gradual in its course, and in simple uncomplicated cases its evolution is in exact ratio to the development of the intestinal lesion. In typhus, on the other hand, the disease is very violent at first, and afterwards becomes suddenly or alternately better or worse, and often in those cases which appear the most unfavourable, it advances rapidly and spontaneously to a favourable termination. Ataxia characterizes it more than it does typhoid fever.

As regards the treatment of the two diseases, Professor Forget says that while, in typhoid fever, this must always be adapted to the peculiarities of each particular case, special attention must be paid to the intestinal ulcerations which are present during its course, and that all those medicines should be avoided which are calculated to aggravate these lesions of the alimentary canal. There is no need for this caution in cases of pure typhus.—*Gaz. Méd. de Paris.*

New Remedy for Pruritus Vulvæ.—Dr. Scholz recommends an Indian plant, the *Caladium seguinum*, which is used by the natives of India as an anaphrodisiac, for the treatment of those cases of this most distressing malady, which are due rather to a hyperæsthetic condition of the parts, than to any lesions of the mucous membrane of the vulva. The plant belongs to the *Aroideæ*. Scholz has used it with great success in two cases which had previously resisted all remedies; and he administered it in the form of an alcoholic tincture, in doses of six drops.—*Arch-Gen. de Méd.*

Vinegar in Scabies.—Professor Le Cœur of Caen recommends, for the cure of itch, forcible frictions of the parts affected with a hard sponge, soaked in good vinegar, performed thrice daily, so as to penetrate the skin, and rupture the vesicles. He has tried this treatment, with the most complete success in ten cases, the average length of the treatment being less than five days. He thinks this treatment preferable to all others on account of its speedy action—its inexpensive nature—its freedom from unpleasant odours, and its easy application. He suggests that similar results might probably be obtained by frictions with the mineral acids dissolved in water.—*Gaz. des Hop.*

Oxide of Copper Ointment as a Discutient.—Professor Hoppe of Basle attaches very great importance to an ointment made with the black oxide of copper, as a discutient application. He uses it in the following cases:

1st. In *opacities of the cornea* (half a grain to ℥j of axunge, increased to 5-10 grs.), a small quantity introduced into the eye twice or thrice daily, causes them to disappear.

2nd. In *diseases of the eyes*, especially in inflammation of the lachrymal gland, of the cellular tissue of the orbit, and of the palpebral mucous membrane, he says, it produces excellent effects when it is rubbed on the temples instead of *Ung.*

Hydrarg. He used, in such cases, an ointment made with ℈j. to ℈ij. of oxide, added to twice its weight of axunge, and combined with narcotics.

3rd. In *tumefaction of the external meatus of the ear,* occasioned by chronic inflammation of its cellular tissue.

4th. In *induration of the salivary glands,* which in a few days yields to its influence.

5th. In *enlargements and indurations of the glands of the neck,* it is peculiarly serviceable, causing lymphatic glands which have become sarcomatous, to soften and disappear better than any other remedy. He says, he has seen obstinate, hard, and voluminous swellings yield to a single application.

6th. In *goîtres* of the ordinary kind it is very useful, although it is inefficacious in the hard, fibroid, sarcomatous tumours of the neck.

7th. *Engorgements of the mammary glands,* whether recent, or of old standing, are speedily discussed by it.

In many other maladies, as orchitis, glandular swellings of the groin and axilla, hypertrophies of the liver, spleen, &c., Professor Hoppe believes it to be efficacious. Its employment produces no deleterious effects on the economy, but it may easily produce papular eruptions, which may go on to ulceration. Its employment should be suspended whenever the skin becomes irritated, and an ointment of zinc may then be substituted. Hoppe uses it in proportions, varying from 15 to 30 grains to the ounce, of axunge. As contact with the ointment is rather unpleasant, the parts to which it is applied should be kept covered by lint and a bandage.—*Deutsche Klinik.*

Anaphrodisiac Properties of Bromide of Potassium. Thielmann recommends this remedy as an excellent anaphrodisiac in satyriasis, in the frequent and painful erections during gonorrhœa, in spermatorrhea, and in nymphomania. He administers it in doses of from 2 to 3 grains every two or three hours; and, at the same time, enjoins a mixed vegetable and milk diet, and forbids all acid substances.—*Med. Ziet. Russi.*, 1, 1854.

Benzin or Benzole as a Remedy for Animal Parasites. Our readers are probably aware that benzin or benzole is a clear, colourless fluid possessed of a pungent etherial odour, which is produced by the decomposition of benzoic acid, or other organic substances, at a light temperature. It was long ago ascertained by Milne Edwards that its vapour was very fatal to insects. This property has led M. Reynal, of the veterinary school at Alfort, to employ it for the treatment of pedicular maladies among animals. He has found that it destroys the parasites in these diseases, more surely, and with more safety to the animal, than tobacco-juice, mercurial ointment, or any other of the many remedies used. It destroys the epizoa without at all injuring the skin.

It is proposed to use this fluid in the parasitical diseases of the human skin, especially in pityriasis, or morbus pedicularis, and in scabies, &c.—*Bulletin Gén. de Therapeutique.*

Use of Cubebs in Infantile Enuresis. By Dr. Deiters.—This author has found cubebs more effectual than any other remedy in curing the incontinence of urine so common among children. This complaint may depend on atony of the bladder, or on the presence of intestinal worms. In the former case, the cubebs acts as a tonic, in the latter as a valuable anthelmintic. The medicine requires to be given in considerable doses; two pinches (*i. e.* a few grains or *Zwei Messerspitzvoll*) for infants, and half a teaspoonful twice or thrice daily for children of a somewhat more advanced age. Its effect is speedy and permanent; and although occasionally it happens that during its administration the incontinence returns at periodical or irregular intervals, these recurrences gradually become less frequent, and eventually disappear altogether. To effect a radical cure, the author has often found it necessary to continue its use for a period of from three to eight weeks, and he has never observed any injurious effects from its administration.

Deiters observes that he has found the same remedy most efficacious in checking nocturnal emissions in cases of spermatorrhœa.—*Preus. Varein Zeitoch.*

Application of the Nitrate of Silver for the Cure of Prolapsus Ani, under the care of Mr. Lloyd in St. Bartholomew's Hospital. The plan is to smear the whole surface of the protruded bowel with the solid caustic, and then return it. The application is repeated once in a week or fortnight, as may be requisite. Mr. Lloyd states that he rarely found it necessary to employ it more than three or four times; and further, that although the plan had been one invariable resort with him, for a long series of years, that he had never known any untoward consequences to result. In cases in which the protruded bowel has become swollen, and is difficult of reduction, the effect of the caustic is surprising. In one such case, the mass could be easily seen to diminish in size under its influence. Mr. Lloyd does not limit the use of this remedy solely to prolapsus, but adopts it also in cases of hæmorrhoidal congestion, and thickening of the mucous membrane about the verge of the anus.—*Med. Times.*

DUBLIN: PUBLISHED BY W. B. KELLY,
8, Grafton-street.

LONDON: S. HIGHLEY, 32, Fleet-street.

EDINBURGH: MACLACHLAN & STEWART.

February 15, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.

SENT FREE BY POST.

Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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STEEVENS' HOSPITAL.

Clinical Observations on Stricture of the Urethra.

BY SAMUEL G. WILMOT, M.D.,

SURGEON TO THE HOSPITAL.

IN order that you may rightly understand the principles upon which the treatment of stricture of the urethra is to be conducted, it will be necessary first to give a sketch of the classification, the pathology, and the causes of the different strictures met with in practice. The grand division of strictures is into the temporary and the permanent. The temporary are of two kinds, the spasmodic and the inflammatory. The spasmodic stricture results from muscular contraction, and in its genuine form can occur only at the membranous part of the urethra, since this is the only portion of the canal which lies in direct contact with voluntary muscles. There is reason to believe, however, that spasm of a more feeble and a different kind may occur at any point of the urethra; for, according to the researches of some eminent modern anatomists, minute, involuntary muscular fibres surround the canal throughout its entire length. The existence of these fibres was long ago inferred by John Hunter, but they have latterly been demonstrated by the microscope, the power of which instrument has, within the last few years, been so much enhanced. The inflammatory stricture results from acute inflammation of the lining membrane of the urethra to a variable extent, and is generally the immediate effect of acute gonorrhœa. Now, these two kinds of stricture, the spasmodic and the inflammatory, rarely occur separately, they are almost invariably associated; indeed, it is difficult to see how the latter can exist long, without the former being superadded. Acute gonorrhœa is the great source of this two-fold obstruction in the urethra, and you may find a difficulty in understanding this, seeing that genuine spasmodic stricture occurs at the membranous part of the canal; and that gonorrhœal inflammation is confined to a couple of inches of its anterior portion. It occurs in this way. When gonorrhœa becomes much heightened from any cause, or where the disease, though not very acute, occurs in a person of irritable, or scrofulous habit, the inflammation is apt to transgress what is called "*the specific distance;*" it will then run along the entire course of the canal, and arriving at the membranous part, irritation is propagated to the muscles around it, and they are thrown into complete spasm. There is reason to believe, that in some instances of this two-fold sort of obstruction, the narrowing of the urethra is seriously increased by the exudation of a regular false membrane, similar to what occurs on a large scale upon the respiratory mucous membrane in croup. This, though undoubtedly rare, is probably more common than has been supposed, and it may account for some of those extremely aggravated cases of dysuria, supervening upon acute urethritis, which seems to be so little influenced by treatment calculated merely to reduce vascular turgescence and to relax spasm.

The permanent stricture is the effect of chronic inflammatory action, which works slow changes in the urethra, the issue being the formation of an adventitious structure, by which the canal becomes gradually narrowed. It is formed from lymph that becomes gradually converted into a regular fibrous tissue; hence, this sort of stricture is also termed organic. The changes which take place are these:—Interstitial deposit of lymph-fibro-plastic material first takes place in the mucous membrane, by which it becomes thickened or puckered in such a way as to encroach on the calibre of the urethra; this constitutes the simplest form of organic stricture met with. In worse cases the deposit of lymph extends to the submucous tissue, its cells become agglutinated, and, in process of time, a fibrous tissue is produced, by which not only the canal is contracted, but its elasticity and mobility are destroyed at that point. In extreme cases the corpus spongiosum itself becomes implicated, its cells are obliterated, and a dense structure is formed, which assumes, after the lapse of time, a regular cartilaginous substance. This sort of stricture can be felt externally, as you may perceive in the case of Johnston, No. 1 Ward, where the obstruction is situated in front of the scrotum. In very bad strictures, the three tissues I have named, the mucous membrane, submucous tissue, and corpus spongiosum, are generally all involved in the adventitious product, but each may be the principal seat of the deposit, and the mucous membrane may even be exclusively so. Now, according to the exact tissue which chiefly causes the obstruction, will be very much the sort of instrument you employ for its removal, and the ease or difficulty with which a complete cure is effected. For instance, if the stricture be composed merely of a thickening of the mucous membrane from deposit of lymph, it is readily removed, and that without advancing beyond a bougie of No. 8 or 9 size. If the submucous tissue be involved, then it is more difficult to remove the obstruction, and the urethra must be dilated further than in the former case. If the corpus spongiosum be the principal seat of the adventitious deposit, then the stricture is most difficult of cure, and in order to effect it at all it is necessary to advance to the fullest sized instrument, but, do what you will the cure is temporary; in most cases the disease returns. Now we meet with three principal species or varieties of permanent or organic stricture. The first consists of a transverse fold of mucous membrane and submucous tissue, in which lymph has been interstitially deposited; this kind of stricture was particularly described by John Hunter, and has been called the "chorded." The second is the "long stricture," so named because it occupies from a quarter to one, two, three inches, or more, of the canal; in it the submucous tissue is always involved, and sometimes also the corpus spongiosum. You may sometimes, but very rarely, meet with cases of long stricture to such an extent, as to involve the entire length of the urethra; the canal becomes contracted from one end to the other. The pathology of such strictures is peculiar. The third is called the "bridle stricture," and is a rare form of the disease; it consists of one, two, or more bands, which stretch across the floor of the urethra, being attached only at their extremities. Now the great remote cause of permanent or organic stricture is gonorrhœa. I know this has been denied by a few, amongst whom is the celebrated John Hunter. It has been contended that gonorrhœa is a disease of extreme prevalence, still very few comparatively get stricture; why, it is asked, should not the latter be more universal if the former be so efficient or fertile a cause of it as has been represented? But this, to say the least of it, is an extremely weak argument, and raises a question quite different from the one sought to be established. The question is not what proportion of cases of gonorrhœa disappear without terminating in, or laying the foundation of stricture, but when stricture has occurred what is its cause in the majority of cases. Gonorrhœa often is, no doubt, cured completely without leaving behind it that condition which eventuates in the formation of stricture; but, when the latter occurs, how seldom is it not traceable directly to the former, and traceable very often, not through any long interval, or to a distant period, but along a chain of events the links of which are so close as to show clearly the relation of cause and effect existing between the two diseases.

To deny this relation upon the ground I have mentioned is as absurd as it would be to contend that the cause of hepatization of the lung should not be viewed as pneumonia, because in many instances that disease is resolved in its first stage; or that a wound is not the exciting cause of inflammation (erysipelas for example), when it supervenes upon it, because a wound may heal up without any evidence of inflammation whatsoever. I say it is impossible to observe the regular gradations from gonorrhœa to gleet, and from gleet to confirmed stricture, or to be able, as we generally can, to trace the stages in the opposite direction from stricture to gonorrhœa, without recognizing the obvious relation which these two diseases hold to each other. Gonorrhœa is a fertile cause of stricture, because it is so apt to degenerate into that chronic inflammatory process termed gleet, during the existence of which those organic changes occur which lead to the formation of the adventitious structure. I have dwelt particularly upon this point, because it is most essential, practically, that it should be decided one way or other. For if gonorrhœa be not a common cause of stricture, then there is comparatively no risk in neglecting the former disease, nor no necessity in curing it speedily; but if the two diseases stand ordinarily in the relation of cause and effect, then the sooner gonorrhœa is cured the better, and that must be viewed as the best plan of treatment which removes it most quickly and decisively, be it balsam, cubebs, or injections. As regards injections, many consider that their employment is highly productive of stricture; but this is, I am confident, an opinion formed without good foundation. Injections often appear to act as the exciting cause of stricture, because they are had recourse to at a period when stricture is either forming or formed, and since cessation of the urethral discharge in general soon follows their use, nothing is more likely than for a superficial observer to connect their action with the development of the stricture which follows. If, however, injections be employed at the proper period in gonorrhœa, and with certain precautions which it is not necessary at present to mention, they will be found, so far from inducing stricture, to obviate it by cutting short the urethral inflammation, and thus prevent it from lapsing into the chronic form. So much for the classification, pathology, and causes of stricture of the urethra; now for their treatment.

The treatment of stricture is altogether mechanical, and the means employed may be divided into three methods: the use of bougies or catheters, the destruction of the stricture with caustic, and the division of it with the knife. We shall merely consider the first method. A stricture may be cured by the bougie upon two principles—absorption and ulceration. It is by absorption we generally wish to cure the disease, as it is the simpler method, and the one freest from danger. In books, you are told that the bougie cures stricture upon the principle of dilatation; but this is a very erroneous statement. How can a stricture be *cured* by dilatation? No doubt you pass through some kinds of tight stricture by dilating them with the instrument; this you observed in the case of Collins, No. 11 Ward, where, in order to overcome a very obstinate obstruction, I was obliged to force a conical metallic catheter through it. But this does not *cure* the stricture; it can alone be removed by absorption. The contact of the instrument with the newly-formed structure, the adventitious deposit, causes the gradual absorption of the lymph, which is followed by restoration of the canal to its original calibre.

When a person comes to you complaining of stricture, your first business is to explore the urethra. Make the patient stand with his back against a wall, and introduce a bougie of about No. 8 size; by this means you ascertain the seat of the obstruction, and some other particulars which may assist you in selecting the sort of instrument suited to the case. It is of advantage to pass the instrument fairly through the contracted part, because when it is brought in contact with the entire length of the stricture, absorption takes place much more rapidly than would otherwise be the result; accordingly you should go on diminishing the size of the instrument to the very smallest if necessary, until you get one to pass. Now a word upon the introduction of very small instruments. A little practice will soon enable you to become adepts in passing large sized instruments; but to use those which are very small and delicate skilfully, requires much more practice and the possession of a larger share of the "*tactus eruditus*." There are two difficulties to be encountered in introducing slender flexible instruments in the case of stricture—one is to prevent their catching in the lacunæ of the urethra, the other to prevent their coiling up or turning at the point. The first impediment I have alluded to sometimes proves much more troublesome than you may imagine, for the lacunæ often become greatly enlarged in cases of old stricture; it can be overcome, however, by adopting the following expedient:—Take a small catheter mounted on its stillet—you can get them of extremely small size below No. 1—and set it to rather a small curve, then holding the instrument with the concavity of the curve downwards, introduce it into the urethra as far as the stricture, or so far as it will go; then turn the instrument round, withdraw the stillet, and pass it on; you thus avoid most of the lacunæ, and particularly the lacuna magna. The second difficulty can be only experienced well by those who want proper tactile sensibility. It is generally easy enough to distinguish between the sensation conveyed when an instrument is coiling up and when it is taking its course fairly on into the bladder. If an instrument shorten because it is coiling, in proportion as it shortens the resistance to the hand increases, whereas if it be taking its proper onward course as it shortens, the resistance diminishes. When using small instruments in stricture, you should feel about with the greatest gentleness and delicacy until you become sensible that the point has passed the obstruction; you may then push it on without hesitation. I have said it is of *advantage* to pass the instrument completely through the stricture, but such is not *necessary*; a cure can be otherwise accomplished, though more slowly, upon the same principle. If you cannot get an instrument to pass, take one of about No. 4 size, introduce it down to the stricture, keep it pressed against it for a few minutes; repeat this every third day for a short time, and the adventitious deposit will become gradually absorbed from before backwards, and ere long the same instrument, or one a little smaller, will slip through: you then, by degrees, increase the size of the instrument, until the obstruction completely disappears. Now every practitioner who has had any experience in the treatment of stricture is aware, that an instrument, one even of considerable size, may be passed several times in succession with the greatest ease in the same case, when, upon some unexpected occasion it becomes repulsed.

This event is produced by spasm. The patient, perhaps, has exceeded the bounds of prudence in taking wine or spirits, or he has been exposed to wet or cold, or he has fatigued himself by over-much walking; the result in any of these cases is that slight inflammation, or a state bordering upon it, is set up in the stricture and its vicinity, and the irritation being propagated to the muscular fibres around, spasm is the consequence. We have already seen that spasmodic and inflammatory stricture are almost always associated; but permanent stricture, though occurring frequently in a separate form, also very often coexists with the spasmodic, and their combination constitutes what is called "mixed stricture." Now, whenever you meet with opposition in passing an instrument, which you have frequently introduced before with ease, make use of no force; take one a couple of sizes smaller, pass it down to the stricture, keep it pressed gently against it for a few moments, and the probability is the spasm will relax, and the instrument will slip through. If not, lay aside the instrument, give the patient an opiate, and do not attempt to re-introduce it for some days. You will frequently, however, meet with cases of stricture, in which the tendency to spasm is so strong, that it will occur apparently without any assignable cause; these are most annoying cases, for you can make but little progress in the cure of the disease: every time you introduce an instrument, and very often no matter how delicately it may be done, the patient is seized with spasm and complete retention of urine may follow. Now, this extreme proneness to spasm is found to depend on one of two conditions—irritability of the system generally, or irritability of the urethra. The first condition occurs in persons of a nervous temperament, and in those particularly who have led a luxurious life, or who have injured their health by habits of dissipation; very frequently this state is associated with aggravated dyspepsia and derangement of the hepatic function. In all such subjects you must be most gentle in introducing instruments, you must also leave a longer period between each introduction than is ordinarily observed, and you must take care to increase their size very gradually; indeed you should never attempt to pass an instrument that was not at least a size smaller than what might be got through with a little pressure. Besides these expedients, you must make the patient attend strictly to his health, and avoid the causes of spasm already mentioned; you should also prescribe for him a course of tonic treatment, of which sea-bathing is a very important element. The second circumstance which often mars the cure of stricture in a most perplexing manner, by inducing spasm, is local irritability. This consists in a state of high sensibility, depending on a condition, *minus* inflammation, which affects not only the stricture itself, but the lining membrane of the urethra in its neighbourhood, sometimes to a considerable extent. This "morbid sensibility," as it has been termed, is frequently associated with the other condition, that of general irritability, and seeming to depend on it; but most usually, it is the result of the stricture being neglected, or mismanaged; and very often, it results from the patient's having contracted gonorrhœa during the existence of the former disease. Where this local irritability or morbid sensibility is present, there is, in general, more or less discharge from the urethra, and there is what the patient views as singular, a remarkable fluctuation, in respect to the ease with which he passes urine; one time he will make water in a tolerably full stream, on the next occasion it escapes in a mere thread, and with considerable difficulty; and the sensibility of the urethra is so much exalted, that the patient will often cry out vigorously when the instrument touches the diseased spot, which may commence considerably anterior to the stricture, and frequently, he has not fortitude enough to allow you to pass on the instrument, but insists that it shall be withdrawn.

To remove this condition of the urethra, which so much retards the cure of stricture, Sir Benjamin Brodie has recommended the local application of nitrate of silver to a very slight extent; and in obstinate cases it is sometimes absolutely necessary to resort to this practice, but in ordinary cases it is not required. If you use the instrument with great gentleness, not being anxious *at once* to get through the stricture, being content for a time merely to pass a small well-oiled bougie down to the obstruction, and no farther, so as to accustom the urethra to its presence, and that you observe, also, those precepts which I said should be obeyed, where the complication of spasm with stricture is referrible to impairment of the system at large, the sensibility will become gradually blunted, and the cure of the stricture will be accomplished with certainty, and without any untoward consequences. There is one very unpleasant symptom sometimes connected with the condition of urethra I described, and which is always a source of great mental annoyance to the patient. I allude to spermatorrhœa. Now, if the emissions have not existed prior to the establishment of the stricture, you may calm your patient's uneasiness, by assuring him that they are dependent upon the peculiar condition of urethra under which he labours, and that as soon as it is removed they will disappear. The patient, however, will in general ask for some medicine to check or diminish them, and the best I have found for this purpose, in such cases, is the sulphate of zinc, the dose of which may be gradually increased from one grain to five if necessary; its efficacy is sometimes enhanced by combining it with the sulphate of quina; one or two grains of the sulphate of zinc, and one of sulphate of quina made up into pill with extract of rhubarb, or with a little compound rhubarb pill, so as to obviate constipation, will be found an admirable combination. If there be, as there sometimes is, urethral discharge as well, the sulphate of zinc will often check or diminish it, besides influencing the other symptom.

You may now naturally ask, does the method of treating stricture with the bougie, on the principle of absorption, ever lead to bad consequences? Simple as the plan may appear, it is capable of producing very serious results. One of these you witness in the case of Collins, No. 11 Ward, but the case of Fitzgerald, No. 14 Ward, which you saw a few weeks ago, was a better example of the same; after the introduction of the instrument, the patient is seized with a rigor, which is sometimes followed by fever of no little seriousness if it be neglected. This result is frequently due to improper violence in the use of the instrument, but it will often occur where not the least blame is to be laid to the surgeon. Whenever a patient is seized with a rigor from the passage of an instrument, give him for the future an opiate immediately after it, and if this does not succeed in preventing its occurrence, make him take a moderate one before, as well as a full one after the operation. Sometimes, however, the susceptibility to rigors is so great, that do what you may they will occur; every time you introduce an instrument a rigor follows, and a formidable train of febrile symptoms ensues. The constitutional disturbance is sometimes so severe as to leave the health shattered for a long time, and in cases of bad stricture, especially where there is any renal complication, it will often bring the patient to the brink of the grave. Sir Benjamin Brodie has recommended, that in cases where a rigor occurs every time an instrument is passed, a gum-elastic catheter should be permanently retained in the bladder. He says, the rigor always occurs after the patient has made water subsequently to the withdrawal of the instrument, and he is of opinion, that if the urine be prevented from coming into contact with the urethra, this event will not occur. Any suggestion coming from so high an authority must be received with the greatest respect, but this is one that cannot be always adopted. Few can bear a catheter in the bladder for any length of time,—it is apt to excite great irritability of the organ, and considerable febrile disturbance,—and fewer still will submit to the inconvenience which the carrying out of such a plan necessarily entails. Very often, by taking great care to pass the instruments gently, to increase their size gradually, and to leave a long interval between each introduction, using opiates as before stated, and keeping the patient for some time on the sulphate of quina, you may proceed with the cure of the stricture successfully, without interruption from rigors. Sometimes, however, no matter what course you pursue, rigors will be excited every time you attempt to introduce an instrument, and if you persevere, you will seriously damage the patient's health. In such cases lay aside the instrument, and make the patient change the air; this is the most effectual means of breaking the susceptibility to rigors. If he be in hospital send him to the country, and you will find that, in nine cases out of ten, he will return in a short time with his health improved, and the susceptibility to rigors so much abated, that you can follow out the cure of the stricture with success, and without, at least, any *marked* interruption. There is a form of rigor resulting from the employment of instruments for the cure of stricture, which it is most important to distinguish from that I have just noticed. The rigor I allude to is feeble compared with the other, it is rarely followed by a hot and sweating stage of any marked character, and never glides like the other into regular fever. This sort of rigor occurs in persons of a highly nervous, irritable temperament; they are mostly dyspeptic and hypochondriacal, complaining of many symptoms, which are referrible more to imagination than to actual physical derangement. I think mild sedatives, such as hyoscyamus, are preferable to opiates in these cases, but the treatment I have found most efficacious is the administration of the valerianate of zinc, and the use of the shower-bath.

The consideration of the other results of the treatment of stricture by the bougie we must reserve for a future occasion.

MEATH HOSPITAL.

Observations on Purulent Urine, occurring in Connexion with Pyæmia and Suppuration in distant Parts of the Body.

BY DR. LEES,

PHYSICIAN TO THE HOSPITAL.

In an Article on "Pus in the urine, as an aid to the diagnosis of some diseases of the genito-urinary system," published in the "Dublin Quarterly Journal," for May 1851, Mr. Hamilton has adduced examples of two sets of cases in which pus is present in the urine. One, in which "pure pus may get into the bladder from the bursting of an abscess in the adjacent areolar tissue, or some neighbouring organ;" the other, in which "pus is secreted by the vesical mucous membrane itself, the result of inflammation," and he has laid down important diagnostic marks between these two forms. But there is another very important condition of the system in which we also occasionally meet with pus in the urine, and to which I wish to call the attention of the profession, as I think it may be of some use to us in forming a prognosis in a very serious form of disease, namely in pyæmia, or that state in which pus or its elements are circulating in the system. It is admitted by all our authorities that the symptoms of pyæmia are due to the presence of pus or a pyogenic fluid circulating in the blood, but it is not yet fully decided whether the pus formed in the veins be the result of secretion from the inflamed surfaces, or of direct metamorphosis of the blood itself; and it is also a disputed point with many, whether the pus formed within veins at the part originally inflamed be substantively transmitted through the medium of the circulating current to the lungs, the liver, and other parts of the body, to accumulate at certain points, or whether it be actually generated in the parenchyma of these organs. M. Lebert, who has investigated this subject with much attention, states particularly that the parts which are the seat of purulent effusions are truly inflamed, so that the term secondary depôts, which is often applied to those lobular or metastatic abscesses, as they are termed, is incorrect, the pus being actually generated, not merely deposited in the part. He has made several careful observations, with a view to discover whether the pus-globules are actually present in the blood of the pyæmic, and concludes "that they cannot certainly be detected; for even in the blood of animals that died from the effects of pus injected into their veins, the globules of pus could only once be discovered," so that he infers it is probable that they are rapidly destroyed after having entered the circulation. Mr. Coulson, who has paid much attention to this subject, in connexion with suppuration of the joints, is of opinion that "in these cases the contamination of the blood depends on the admixture of pus, as such, circulating with the vital fluid. The pus is not absorbed, but admitted directly into the circulation through some breach of surface;" and in support of this opinion he details a case of puerperal phlebitis, in which "the blood of the vena cava, near its entrance into the heart, was examined with the microscope by Mr. Gulliver and the late Mr. Dalrymple, who discovered true pus-globules in it." Two cases, in which I have lately detected the presence of pus in the urine in connexion with suppurative inflammation, may assist us in shedding some light on this abstruse subject. The first case was that of a girl, æt. twenty, who was admitted to the Meath Hospital, February 8th, 1854, in a state of extreme prostration, suffering from general bronchitis, indicated by constant cough, with muco-crepitating râles all over both lungs, and copious muco-purulent expectoration; she had profuse nightly perspirations, and also diarrhœa; her aspect was remarkably pallid and anæmic; her pulse 140, very feeble. Dr. Head, under whose care she had been as a dispensary patient, informed me that ten weeks previously she had been bled in the right arm for an attack of bronchitis, the puncture inflamed, and suppurated; this was followed by frequent rigors, high inflammatory fever, and inflammation of the veins of the arm, which became painful and hard up to the axilla; she next complained of violent pain in the left shoulder, which was relieved by opium; in a few days the left hip joint was attacked with pain, but no swelling nor discoloration; there were frequent rigors, followed by perspiration, the pulse ranging from 100 to 140. The right shoulder now became very painful on the least motion, and tender on pressure; in a few days the left elbow joint was attacked in a similar way; all this time she suffered from symptoms of general bronchitis, with constant rigors, perspirations, and occasional attacks of diarrhœa. She had been treated most judiciously by Dr. Head (who had recognized the case as one of purulent absorption) with opium and quinine, along with nourishing diet and wine; but as her family were not able to afford her proper nourishment, he sent her into the Meath Hospital, in the state above described.* On admission she presented the aspect and the symptoms of a person far advanced in consumption, but the absence of any localized dulness in the upper part of the lungs, or of the physical signs of ordinary tubercular phthisis, negatived this supposition; the doubt then arose in my mind whether it might not be an acute tuberculosis of the lungs, as the profuse sweatings and extensive muco-crepitating râle heard all over the lungs might depend on a general acute development of tubercle; but the history of the case inclined me to the opinion of Dr. Head, that all the symptoms were caused by the presence of pus or its elements circulating in the system, and the examination of her urine, which was conducted by my very intelligent pupil, Mr. Leet, confirmed us in this view, as we found that the urine was albuminous and contained pus, although she stated that she was not suffering from any purulent or leucorrheal discharge. I give the result of two analyses as made by Mr. Leet.

"One pint was passed during twenty-four hours, of a pale yellow colour, disagreeable ammoniacal odour, depositing a purulent sediment after eight hours' rest, having a faintly alkaline reaction, and a specific gravity 1010.6.

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* Reported by Mr. Ulysses Fitzmaurice.

Analysis in 1000 parts:—

Solid constituents,	24.2
Water,	975.8
Urea,	11.9
Uric acid,	0.0
Albumen,	5.5
Fixed salts,	4.2
Organic matter,	2.6

"A pint and a-half was excreted in twenty-four hours on 18th ult., three days after last analysis.

"It was a deep yellowish-red colour, same disagreeable odour, sediment more copious, but similar in composition to last. Reaction to test paper less distinctly alkaline. Its specific gravity was 1019.8.

Solid constituents,	45.3
Water,	954.7
Urea,	23.5
Uric acid,	0.0
Albumen,	2.9
Fixed salts,	12.6
Organic matter,	6.3"

Now, in this case we had no doubt but that pus or its elements were circulating in the blood, indicated by the frequent rigors, the very rapid pulse, the copious perspirations, and the presence of pus in her urine, by which the system tried to eliminate the poison, and thus furnish a safety valve to prevent the mass of blood from being contaminated; and we were confirmed in this opinion by the formation of an abscess in the lumbar region, after the opening of which she rapidly recovered. The very judicious tonic treatment adopted by Dr. Head enabled the patient to resist the poisonous effects of the pus, and as the same treatment was persevered in, her symptoms steadily improved, the pus gradually disappeared from her urine, and she recovered perfectly. Another case, which I think tends to corroborate this view of the subject, has occurred to me very recently in the person of a lady suffering from mammary abscess, whom I was in attendance on with Dr. Charles Johnson and Mr. Hamilton. In this case my attention was directed, two days before the abscess was opened, to the very turbid condition of the urine, which presented the appearance of muddy water, was acid, of specific gravity 1.020, coagulated densely by heat and nitric acid; and on examination with the microscope (in which I had the advantage of Mr. Thomas Hayden's assistance), we found it loaded with perfect pus-globules, exhibiting the characteristic reaction on the addition of acetic acid. I confess that I felt much alarmed about this case, as I feared it might be one of purulent infection of the blood, particularly as she had complained a few days previously of severe pain in the dorsum of the foot, and also suffered from profuse perspirations, which symptoms, taken in conjunction with the previous occurrence of rigors, and attended with the presence of pus in the urine (there being no disease of the genito-urinary passages), led me to apprehend a serious result, in which I was fortunately mistaken, as after the abscess was opened by Mr. Hamilton she recovered rapidly, and the pus gradually disappeared from her urine. In this case the quietude of the circulation was remarkable, as after the abscess was opened, the pulse never rose above 80, though pus continued in the urine for some days. Now, as a general rule, in all cases of purulent infection of the blood, the circulation is greatly accelerated; and this fact made me hesitate to record the above case as one of pyæmia, but by a fortunate coincidence at about the same time there occurred under the care of my colleague, Dr. Stokes, in the Meath Hospital, the case of a man who, during convalescence from typhus fever, was attacked with inflammation and suppuration in the region of the elbow-joint, followed by an asthenic form of pneumonia, which Dr. Stokes considered to be phlebitic, depending on a purulent infection of the blood. The pneumonia resolved under wine and ammonia. He now passed under my care, and was then attacked with a large abscess in the gluteal region, when I was surprised to find that his pulse was scarcely excited, beating only 80 in the minute, previous to, and after the formation and opening of the abscess. Now, as in this case neither Dr. Stokes nor I have any doubt but that these local inflammations were the result of poisoning of the blood, although the pulse remained tranquil after the first violence of the attack had subsided, I think I am justified in concluding, that in the case of mammary abscess just related, where pus was evidently formed by, and in the blood itself, there occurred what is termed a vicarious secretion of pus from some part of the genito-urinary apparatus, probably the kidneys; and though the late much lamented Dr. Golding Bird, in his valuable work on "Urinary Deposits," appears to throw doubt on the possibility of such an occurrence, and the absorption of unaltered pus through the capillaries is hardly admissible upon physical grounds, yet, I conceive, that in this case either the nuclei of ruptured pus-globules were carried into the general circulation, or there occurred absorption of the serum of the pus either into the lymphatics, or into the blood-vessels communicating with the abscess by their capillaries, which was then eliminated from the system through the kidneys, by a process similar to that by which cholic acid is eliminated in certain cases of jaundice, as I have shown in the Dublin Quarterly Journal for August, 1854; and I would suggest the propriety of examining the urine for pus in every case of pyæmia, as I think that when we find pus eliminated with the urine in cases of pyæmia (judging from these cases and others that have been recorded, in which large collections of purulent matter have disappeared from different parts of the body contemporaneously with the discharge of purulent urine), the prognosis may be more favourable than in those cases where we cannot detect its presence, just as in jaundice, I think that the detection of cholic acid in the urine may tend to allay our apprehensions of these terrible cerebral symptoms which result from the absorption of bile into the system; and in an analogous way the presence of urea in the urine in cases of albuminuria, may reassure us against the patient being affected with a nearly similar train of symptoms due to the absorption of urea into the blood, and hence termed Uræmia.

An Essay on the Question of Contagion in Yellow Fever.

BY WILLIAM J. CUMMINS, M.D., &c.,

PHYSICIAN TO CORK DISPENSARY, CIVILIAN SURGEON IN CHARGE OF THE DEPOT HOSPITALS IN CORK GARRISON, LATE SURGEON OF R. M. COMPANY.

[Read before the Cork Medical and Surgical Society, December 27th, 1854.]

Mr. President,—I need not apologise for directing the attention of the Society to the much controverted question, as to whether yellow fever possesses contagious properties or not, for living as we do in a city which is in constant and close communication with the West Indies, the hot-bed of this fearful pestilence, it is impossible to know the moment in which we may be called upon to consider the question as a practical one of great importance to ourselves and our city.

This disease, as you are doubtless aware, has prevailed at various periods in Africa, North and South America, the West Indian and other islands, and the South of Europe, under the names of "Yellow Fever," "Vomito Negro," "Vomito Pricto," and "Bulam Fever," and until the year 1849, its geographical range was within forty deg. north, and twenty deg. south lat.; then, however, it prevailed for the first time in Rio Janeiro, twenty-three deg. south, and thence spread early in 1853 to Buenos Ayres, so that it is at present only confined within the limits of forty deg. north, and thirty-five deg. south latitude.

An opinion is entertained by many medical men, that a mean summer range of from seventy-five deg. to eighty deg. Fahrenheit, is an indispensable condition to the epidemic spread of this disease, and from a superficial view of the following facts, the prevalence of such pleasing anticipation may be explained:—

1st. That hitherto no epidemic has occurred in any country possessing a lower temperature.

2nd. That no epidemic has occurred in a tropical mountainous country, though often prevalent in the contiguous plains.

3rd. That a ship attacked by an epidemic, almost always becomes healthy on arrival within a temperate or cold climate.

But on looking closely into these facts, we shall find that they prove nothing; for cholera, which was for many years supposed to be inert in any but a tropical climate, is now known to be just as fatal to life on the snow-covered plains of North Russia, as in its native India; and again, it has been proved, that most probably the specific gravity of the poison which is the exciting cause of yellow fever, is less than that of the atmosphere, by the upper stories of houses and barrack-rooms, though not materially differing in temperature from the lower, suffering in a much smaller proportion. Hence it is argued that the immunity from yellow fever enjoyed by mountain districts, cannot depend alone upon their comparatively low temperature.

Moreover, ships can get rid of yellow fever just as readily by steering to a healthy tropical port, as they can by steering northward, or southward, as the case may be. I have seen numerous instances of this, and have compared my cases with the recorded histories of ships, which have left the tropics to get rid of the disease, so that I have no doubt of the correctness of my assertion.

From these considerations it is evident that no substantial reason can be brought forward, why this pestilence should not prevail in a temperate, or even cold climate; and within the last four years, it has given warning of a disposition to extend its *locale*, by attacking Buenos Ayres, thirty-five deg. south lat., the climate of which is by no means unlike that of England.

Having thus premised that even in this country we are practically concerned with the subject I am about to lay before the Society, I shall mention some facts from my own experience, which bear against the doctrine of contagion, and which, though one-sided, are not partial, for I can conscientiously say, that I have never witnessed a single fact in its favour.

Next, I shall take the liberty of quoting from Sir Wm. Pym's book on the "Bulam Fever," some of his strongest facts in favour of contagion; and, lastly, I shall make some remarks on the general bearing of the question, as thus put forward.

Before I bring forward the result of my own observations on this subject, I may mention that my experience has been of a kind peculiarly favourable for its investigation, as I was in Rio Janeiro the greater part of the time yellow fever was prevalent there; and shortly after I had returned home from that station, I was ordered to the West Indies, and arrived there in the "Conway," just after the fever had broken out at Barbadoes and St. Thomas', and remained until long after the disease had ceased amongst us, and had travelled northward to Bermuda and North America. During that period I had served on almost all the inter-colonial mail routes; those are nine in number, and connect, by way of St. Thomas', almost all the West Indian islands, the Spanish Main, Mexico, Demerara, Honduras, Savannah and United States with each other, as well as with the Pacific and England, twice every month. I need not say that countless embarkations and disembarkations of passengers and mails were continually taking place at all these points, for quarantine was never even thought of.

Now, when I mention that every one of the ships engaged in this service was more or less infected with yellow fever for at least twelve months, I am sure you will admit that their surgeons were more than ordinarily competent to form an opinion as to the contagiousness or non-contagiousness of yellow fever.

I do not remember one who did not laugh at contagion.

I shall now proceed to mention various cases of the introduction of persons suffering from yellow fever into healthy towns, passing by the innumerable instances I have witnessed of *healthy* passengers and fomites going ashore under similar circumstances, and with the same result.

On the 23rd November, 1852, the "Conway" arrived at Jamaica from St. Thomas, an infected port, with several of her crew suffering from yellow fever; I was her surgeon at the time, and sent two of these patients to the public hospital at Kingston, where I accompanied them myself. Dr. Scott, the physician of that institution, informed me that the island was healthy, and that yellow fever had not prevailed there for several years; but that the "Medway," the last mail packet, had left one of her men behind, who was now convalescent from that disease. He informed me further, that this man had not been separated from the other patients, as it was not customary to take any precautions against contagion in yellow fever.

The "Orinoco" was the next arrival in this island from St. Thomas. She sent four cases to hospital; all of which died with black vomit.

The "Magdalena," a fortnight after, arrived from the same port, and sent several cases to hospital.

Next came the "Parana;" she also sent a number of her crew sick of yellow fever ashore—the men to hospital, the officers to lodgings in one quarter, and the engineers and warrant-officers to a house in another quarter of Kingston. Many of these died of black vomit, in each of the three points.

Notwithstanding this series of importations, extending over a considerable period of time, Jamaica continued healthy until March or April, 1853, from four to five months after the first importation I have mentioned. At this time cases may have been imported, and successions nicely and accurately traced for aught I know; but I think it will be the unanimous opinion of the Society that it spread there in the ordinary course of the epidemic, which had commenced in Rio Janeiro, in 1849, and travelling northward had visited in succession the northern Brazilian provinces, French, Dutch, and British Guiana, and arriving in the West Indies had attacked the Windward Islands in 1852, and Jamaica, an island to leeward, in the Spring of 1853, whence it subsequently spread towards the end of 1853, and the beginning of 1854, to Bermuda and North America.

After leaving Jamaica, the "Conway" proceeded on her voyage to Savannah, merely touching at some of the Bahama Islands; thence she sailed for Navy Bay, on the isthmus of Panama, where a boy, who had died of yellow fever, was buried on shore close to the town, without giving rise to a single case of the disease.

On the 9th November, 1853, the "Esk" arrived at Nassau, New Providence, and sent several cases of yellow fever ashore, which were distributed to three separate houses; two of these had black vomit, and two died, but the disease never attacked a single individual of the inhabitants, although no precautions were taken to prevent the freest intercourse.

On the 25th of June, 1853, while I was surgeon of the "Medway," an Italian lady, ill of yellow fever, was carried ashore at Navy Bay, and left at lodgings where she diod. I heard afterward that her friends and other passengers, who had also made the voyage from St. Thomas' to Navy Bay with us, crossed over the isthmus to Panama, where many of them died of yellow fever, which they had carried in their systems. Neither of these towns were attacked, although no precautions were taken to prohibit the freest intercourse with the sympathising inhabitants.

The "Trent" in the same way left several of her men sick of yellow fever ashore at Carthagena, but they caused no spread in that city.

I have thus brought forward numerous instances of the introduction of actual cases of yellow fever into healthy inter-tropical countries, all favourably circumstanced, as far as the predisposing causes of the disease are concerned, for its spread; and many of these places where former epidemics had committed devastation.

I shall pass on now to the consideration of the other side of the question, and in the absence of facts from my own experience, quote from Sir William Pym's work.

In his preface, he directs particular attention to certain pages, as containing marked instances of spread by contagion. I have read them carefully, and shall glance at them in detail, making a few remarks in passing; but reserving the general consideration of them until I have mentioned them all.

1st.—In 1800 and 1803, although yellow fever prevailed in Spain, Gibraltar was not attacked, because a rigid quarantine was established; but in 1804, when there was no quarantine, the disease was introduced by a shopkeeper from Cadiz, who was attacked by it in the north part of Gibraltar, and gave it to his neighbours.

The disease was confined to the north part of the town, and to those who communicated with it, for some time, until an inhabitant moved to the south side, carried it with him, and gave it to his new neighbours; then it became general.

Now, the first part of this interesting little history is valueless, as Sir William admits in another part of his book, that during the time of quarantine in 1800 or 1803, a vessel was admitted to pratique, and her captain died on shore of yellow fever without causing a spread; and the latter part proves too much, for it is stated that, during the "some time" the disease was confined to the north quarter, those who communicated with it were attacked; consequently, the disease ought to have broken out in their homes, even before the "inhabitant" moved his residence to the south side.

2nd.—A few families, who isolated themselves, escaped the disease. These families must have been military, as we are told the whole civil population, except twenty-eight, had yellow fever; of course, then, these families escaped, as they moved out of the localized city epidemic to the neutral ground; but more of this anon.

3rd.—The far greater mortality in the civil population of Gibraltar than in the garrison, because the troops were moved to, and encamped upon the neutral ground, soon after the appearance of the disease amongst them.

4th.—In 1804, two transports arrived at Gibraltar from Carthagena, where yellow fever was raging, and were put in quarantine; seventy-seven soldiers from on board them were sent to two clean quarantine hulks; during the first twelve days after their removal fourteen of them were attacked and sent to the hospital ship, also in quarantine, the remaining sixty-three escaped.

All the crew who remained on board the transports were attacked.

On the 20th of October, more than a month after the arrival of the transports, yellow fever broke out in Gibraltar, in "consequence" (to use the words of Sir William Pym), "(as I suppose), of a breach of quarantine regulations, which, however, could not be detected."

5th.—In the year 1823, the "Bann" contracted yellow fever in the port of Sierra Leone, and having sailed, arrived at the Island of Ascension on the 27th March, with a number of her crew suffering from yellow fever. These were sent on shore, but denied intercourse with the garrison, notwithstanding which, the disease appeared amongst the troops, in consequence of a soldier's wife having washed clothes for one of the "Bann's" crew.

6th.—In 1838, the "Forrester" arrived at Ascension with yellow fever from Sierra Leone, and was placed in rigid quarantine; still the disease appeared four weeks subsequently amongst the garrison. Sir William Pym *"was told"* that the clothes of one of the deceased officers of the "Forrester" were, notwithstanding quarantine, sold by public auction to the soldiers, and to this he attributes the appearance of the disease.

7th.—While yellow fever was raging at Bathurst, four of the inhabitants left for Goro, where they died of the disease. Between three and four weeks after their arrival an outbreak of yellow fever occurred in the latter place.

8th.—The "Eden" and "Champion" arrived from Sierra Leone, at Fernando Po with yellow fever, and, though placed in quarantine, the disease appeared there; at this time the "Sybille" arrived, and received men from the "Eden," who died on board her of yellow fever. The Sybille's crew were soon after attacked.

9th.—The "Eclair," with fever from Sierra Leone, arrived at Bonavista; more than a month subsequent to her arrival, yellow fever appeared in the island, which had been previously healthy; she then sailed for Madeira and England; officers who came on board at both places were attacked with the disease.

10th.—The "Bonetta," a week after leaving Acra, received a prize crew from the "Forrester," an infected ship, *at sea*. These had yellow fever in their systems, and were attacked with it on board the "Bonetta;" her own crew then became affected with the same disease.

(*To be continued.*)

PATHOLOGICAL SOCIETY MEETINGS.

January 20th.

THE PRESIDENT, MR. ADAMS, IN THE CHAIR.

Osteosarcoma of the Lower Jaw.

PROFESSOR R. W. SMITH exhibited a preparation and casts, illustrative of a case of malignant osteosarcoma of the lower jaw, and gave the following history of the disease.

The patient, a female, æt. 68, was admitted into the Richmond Hospital under my care, in the month of November, 1853. She was of sallow complexion, and emaciated; her debility was extreme, her countenance expressed great suffering; her manner was low and despondent; her only complaint, however, was of intense local pain. She stated, that about ten months before her admission, she began to suffer from a deep-seated pain near the angle of the jaw, upon the right side; she attributed it to the presence of a carious tooth, which she, therefore, got extracted; its removal, however, so far from relieving her from suffering, was succeeded by excruciating agony, and a small tumour soon formed in the situation from which the tooth had been removed, and enlarged both towards the interior of the mouth, and also towards the angle of the jaw externally. Small and seemingly insignificant at first, it steadily increased, and the pain remained unmitigated. Having sought relief in vain from the many whom she consulted in the country, she at length came to Dublin, and was admitted, as has been already stated, into the Richmond Hospital. The tumour had now attained the size represented in the cast: was firm, elastic, immoveable, and acutely painful; externally it presented a tolerably uniform surface, but towards the cavity of the mouth it was uneven, and of an intensely red colour, with numerous scarlet vessels wandering over its surface. There were no enlarged glands in the vicinity of the jaw. After her admission into the hospital, the size of the tumour and the pain steadily increased; the teeth became loose, and were pushed inwards towards the cavity of the mouth; the integuments, which were at first moveable, became adherent, and assumed a red, dusky aspect, and numerous arborescent veins could be seen through them. The most prominent part of the tumour was so elastic, and the feeling of fluctuation was so perfect, that many were deceived. She was sleepless, but her appetite was unimpared.

There was a profuse discharge of a thin, colourless fluid from the mouth, of an intensely bitter taste, acrid, and compared by the patient to a mixture of gall and vinegar; its odour was most offensive; she had great dread of this fluid, and to diminish as far as possible this great aggravation of her sufferings and her misery, she kept between her tongue and the surface from which the fluid exuded, cloths and handkerchiefs, which became rapidly saturated. Her appetite still remained unimpaired, and she had a desire to eat more than she did, but was prevented from doing so by the difficulty and pain attending mastication.

Against the month of April, 1854, the tumour had reached upwards above the zygoma, extended backwards to the ear, and filled the whole of the parotid region; downwards it had passed into the neck, while anteriorly it passed the symphysis, and engaged the left side of the body of the jaw; the most prominent and elastic portion of it now gave way, and a small quantity of matter and blood escaped, and afterward bleedings occurred from time to time, but no fungus at any time sprung up. Nothing could surpass the severe intensity of the agonizing pain she now suffered: it ceased not either by night or by day; it was not even subject to remissions, but with a steady and persevering constancy it rapidly wore away her emaciated and debilitated frame. Nine grains of morphine, and half a drachm of cicuta daily, failed to procure even an hour's relief from agony. She had long ceased to entertain any hope of recovery, but now her heart's desire was for death, and at almost every visit which I paid her, she imploringly entreated that some means might be adopted to end at once her misery and her existence. Towards the close of her life, the stomach became very irritable, and frequent vomiting occurred. At length, attenuated to the last degree, and worn out by sleepless nights and days, by the severity of her unintermitting pain, by vomitings, by bleedings, and by profuse salivary discharges, she died about the middle of last summer.

The *post mortem* examination showed that, with the exception of a few small tubercles in the liver, the viscera of the chest and abdomen were healthy. With respect to the jaw, the disease extended from the articulation on the right side to the angle on the left; the bone was fractured in the situation where the disease commenced, and here loose portions of dead bone were surrounded by the morbid growth, which seemed to have originated in the cancelli. The cartilaginous surface of the condyle was healthy, but the disease had extended along the parotid region, and formed a large tumour in the temporal fossa, above the zygoma.

Medullary Cancer of the Breast.

MR. COLLIS presented a specimen of medullary cancer of the breast. The tumour had been observed six years ago, but had grown slowly until six months ago, when it began to increase rapidly. The patient was a woman of sixty-five years, healthy, and with no signs of cancerous cachexia. The tumour, before removal, was the size of an infant's head; it occupied the upper part of the mammary gland, was nodulated, heavy; moveable, and elastic. The skin, though tightly stretched over it, was not altered in structure, except in the most prominent point of the tumour, where it was varicose; in this point only was it incorporated with the substance of the tumour; the nipple was situated below the tumour, and was apparently healthy; there were large blue veins leading upwards towards the clavicle. No enlarged glands were discovered in the axilla or neck; there was only an occasional slight pain through the chest, and no sign of constitutional cancer. The woman wished to have it removed. This was accordingly done on December 20th. Pounded ice and salt were mixed, as directed by Mr. Arnott, in the proportions of one part of salt to two of ice, and applied in a muslin bag to the tumour for rather more than five minutes; the parts were then rigid and white; the process of congelation gave very great pain; the immediate incisions through the skin were almost, but not entirely, painless; but the deeper incisions were accompanied with a very great amount of suffering. There was no hæmorrhage at the time; in the course of four hours a general oozing commenced from the entire of the divided integument, which cold lotions failed to repress, and which required many ligatures to be applied, and pressure to be kept up with the fingers for upwards of an hour, before it was controlled. Judging from this case, Mr. Collis did not think that the freezing plan was suited to large tumours.

On section, the tumour was found to consist of lobules of soft brain-like substance, which microscopic examination showed to be masses of cells with very delicate outlines, and large dark nuclei; there were also great numbers of free granules and compound granular corpuscles; there were three or four deposits of cheesy substance in the middle of the brain-like matter, and from the cut extremities of the ducts, in that portion of healthy gland which was removed with the tumour, there exuded a quantity of thick, dark green fluid, like green paint; this, when examined, was found to consist of blood corpuscles, in a state of disorganization, mixed with a few oil globules and some sebaceous matter; it appeared to be analogous to the dark green substance which is occasionally passed by infants in cases of dysentery, and which is also chiefly composed of blood corpuscles. Mr. Collis had not previously seen such a fluid in connexion with cancer, or other disease of the mammary gland, and his object in noticing the present case was chiefly to draw attention to its nature, as at first sight its appearance in a tumour might create needless alarm. In the present case it was only found in a part of the gland, which appeared both to the naked eye and under the microscope, perfectly healthy.

Diffuse Inflammation supervening on Typhus Fever.

Dr. M'Dowel exhibited the recent appearances in a fatal case of fever, the history of which was as follows:—A girl, ten years of age, was admitted into the Hardwicke Hospital, December 31st, labouring under maculated fever; she passed through the disease favourably, and became convalescent on the fifteenth day. Two or three days previously a small abscess formed below the right ear, and discharged healthy pus; it was apparently a *critical* abscess. For four days the girl remained quite well, but was then reported by the nurse to have relapsed. She had been seized with severe shiverings, followed by fresh fever. It soon appeared that this was not a simple relapse into fever, but the access of a far more serious disease, viz., diffuse inflammation; for in a few days her left elbow joint became swollen and tender, with a pink-coloured blush on the surface. The right elbow soon became similarly affected. Fever of a low type set in, with stupor, constant raving, and great prostration of strength.

There was almost perfect freedom from pain, except when the smaller joints were handled; the pulse was extremely rapid (160), and the respiration was proportionably accelerated. Death occurred on the seventh day of the disease.

Post Mortem Examination.—The lungs were extremely congested, much frothy sero-sanguineous fluid pouring out when incisions were made. On the surface of the lungs were numerous patches of ecchymosis, but no purulent depots. A very thin film of lymph was effused on the pleura covering the base of the lung. No effusion had taken place into the pleura. The tissue of the heart was paler than natural, and preternaturally soft. In the abdomen the evidences of recent peritonitis existed, the anatomical characters of which were somewhat peculiar. Scarcely any lymph could be detected on the serous membrane; in one or two places a thin layer, like a cobweb, could be perceived; there was consequently no gluing of the intestines together, but a considerable quantity of sero-pus, of a light greenish colour, was effused (a fluid precisely similar in appearance was found in the joints of the elbow); with the exception of a few patches of vascularity on the serous surface of the small intestines, there were little traces of increased vascular action. The intestinal mucous membrane was healthy. The liver presented nothing abnormal. The spleen was slightly enlarged, its interior was so softened as to be almost diffluent.

Dr. M'Dowel observed that in this case death was to be attributed to "purulent infection" of the blood, and it could hardly be doubted that the abscess of the neck was the source of this contamination. Having made some remarks on the different ways in which morbid matter may be introduced into the circulation, Dr. M'Dowel said that it was an important question to determine in what manner the infected blood acted on the system. The case just detailed would not, he observed, bear out the mechanical theory of Cruveilhier and others, that the disseminated abscesses, in this disease, were owing to the arrest of the pus globules in the capillaries. No purulent "depots" were, in this instance, found in the lungs, although the pulmonary capillaries were the first through which the contaminated blood had passed. It was more probable that some change had been produced in the chemical, and perhaps likewise in the physical constitution of the blood, by which it was rendered more liable to transude through the vessels, and to set up local inflammations, which were peculiar for the rapidity with which pus has generated, hence the ecchymosed spots in the lungs, and the purulent effusions into the joints and the peritoneum, with but slight traces of vascular action. The morbid state of the spleen was also to be included as associated with this morbid state of the blood.

In conclusion, Dr. M'Dowel observed that this case was one of interest, not only as illustrating the pathology of pyæmia, but also because—1st. Diffuse inflammation was a rare and unusual termination of typhus fever. 2nd. Because critical abscesses rarely prove a source of danger. 3rd. As incidentally proving the independence of typhus fever, and any intestinal lesion.

January 27, 1855.

THE PRESIDENT, MR. ADAMS, IN THE CHAIR.

Case of Cut Throat.

MR. HAMILTON detailed the particulars of this case:—The parts now exhibited were taken from the body of a man aged about 30, who committed suicide by cutting his throat. He was of very drunken habits; and for three months previous to this occurrence, had been constantly under the influence of drink. He then suddenly gave up drinking for a few days, when the usual depression followed; and at this period he was observed to go up stairs into his room, where he remained for a considerable time. At length, the son of the landlord of the place where he lived went up stairs to the room and found him lying on the floor, bleeding profusely from a wound in the throat. He immediately ran for assistance, and on his return found the man with his fingers in the wound trying to tear it open.

The patient was brought into the Richmond Hospital after having lost a great quantity of blood, but when he arrived the bleeding had nearly ceased. There was a large wound found in the throat measuring four inches across, and completely dividing the trachea. It did not occupy the usual situation of suicidal wounds in this region, but divided the thin anterior portion of the ring of the cricoid cartilage and the posterior broad part in such a way, as to leave a part of it hanging in the trachea. The ordinary suicidal wound inflicted in the throat generally takes off a portion of the upper part of the larynx, and enters the space between the thyroid cartilage and os hyoides, but this divided the trachea entirely through at the cricoid cartilage. The case went on very well for the first week; there was nothing done to close the wound, and the patient breathed freely through it. For the first day or two, as might be expected, he was unable to swallow, but afterwards did so, well, and everything promised a favourable termination. He then, however, became affected with cough, which was attended with the formation of a thick, adhesive mucus; and on one occasion, in the course of the night, he was suddenly seized with such a violent attack of dyspnœa, that the resident pupil, Mr. Lloyd, had to be called up, and found him nearly suffocated. The man then expectorated a large quantity of pus, which relieved him for the time. It was evident that some abscess had burst into the trachea, and made its way down into the bronchial tubes.

The patient never went on so well after this; he became subject to severe attacks of dyspnœa; and Mr. Lloyd had to be called up several times at night to attend to him; a good deal of the danger of these attacks was caused by the difficulty of getting up a brown adhesive mucus of a very unhealthy appearance, and mixed with pus; and during one of them, Mr. Lloyd's attention was attracted by something flapping about in the wound, which proved to be a portion of cricoid cartilage. This was removed, and under the circumstances I thought it best to keep a canula in the trachea; it gave him ease, and certainly materially improved his condition, as far as breathing is concerned; but it soon became evident that there was something more deeply seated. He had a hard, quick pulse, furred tongue, had several rigors and severe sweats, and finally died, three weeks after admission.

The instrument which this man employed shows the determined character of the attempt he made on his life. It is an old rusty dinner knife without a handle, with a jagged blunt edge, necessarily forming a very imperfect cutting instrument; yet with this blunt instrument he continued to inflict on himself a large lacerated wound. If the knife had been a sharp one, there is no doubt he would have killed himself at once, for, even with this blunt instrument, he went through the cricoid cartilage and the crico-thyroid membrane down to the œsophagus. The latter, however, was not divided, and the reason he had not succeeded in this was probably owing to the soft nature of the organ, which caused it to yield before the blunt edge of the knife. I may also mention, that he went as near as possible to the carotid artery, but did not injure this vessel.

Now, it is evident the wound in the trachea was not sufficient to cause death; as we know that such wounds are frequently made by the hands of the surgeon without being attended by any serious consequences. Here, however, the cause of the fatal result appears to have been this:—The cricoid and thyroid cartilages are covered by a membrane which is very thin and pale, and little vascular, and its power of vitality seems to be small; we see, accordingly, that when, from disease, an ulcer penetrates through this membrane, and the cartilage is exposed, it frequently dies and exfoliates, and is expectorated, or more commonly keeps up by its presence a fatal irritation. This we observe in chronic ulceration of the larynx from tertiary syphilis.

When he divided the anterior, and part of the posterior ring of the cricoid cartilage (he must have done it with a great deal of violence), about half of the posterior, or broad portion of the ring, was left; but lacerated by the knife, and torn from its investing membrane, and its connexion with the œsophagus, it inflamed, died, and became entirely detached from the mucous membrane, and formed a foreign dead body in the centre of an abscess. This abscess opened into the trachea and into a sac between it and the œsophagus, and continued pouring its contents into the bronchi. We see here, therefore, that independently of this large wound, we have further an abscess with a portion of dead loose cricoid cartilage communicating with the larynx; and this bad matter made its way into the lungs, and there produced incessant and fatal irritation. On dissection we found the lungs in a state of intense bronchitis, the bronchial tubes deep red, and rough, and looking almost granular, and filled with a turbid frothy mucus, which, whenever a section was made, flowed out. You may also see in the large bronchial tubes how intensely vascular they are, the surface so uneven that you might think it was ulceration, until, by applying the magnifying glass, we see that it is not, but turgidity of the mucous membrane and irregularity of its surface. Besides this, there were evidences in the substance of the lungs of purulent absorption, the inferior portion of the right lung was solidified, and contained numerous small purulent depôts the size of peas, such as we observe in purulent phlebitis, and unlike the purulent infiltration and softening of the third stage of pneumonia.

Besides being interesting in other points, I think this case is especially so, as an instance of the injurious effects of the death and separation of a portion of one of the laryngeal cartilages, on the important structures around it.

(*Museum, Richmond Hospital.*)

Perforating Ulcer of the Ilium in Fever; Fatal Peritonitis.

Dr. M'Dowel communicated the following:—

P. Rafferty, æt. 18, admitted into the Hardwicke Hospital, January 10th, 1855, under the care of Dr. M'Dowel. Seven days ill before admission. The symptoms were those of typhoid fever. Diarrhœa was present from the commencement; the discharges were fluid and ochreous; tympanitis and cœcal gurgling were present. The diarrhœa was always controllable by mild astringents.

On the twelfth day, a few bright elevated papulæ appeared on the abdomen ("rose spots"); there was progressive emaciation, but not much debility of the circulation. The eyes were bright and clear, contrasting with the "muddy" eye of typhus; neither deafness nor stupor was present. The tongue was dry, glazed, and fissured.

On the 25th of January he vomited two or three times, and began to sink rapidly, but made no complaint of pain. He died, January 26th, the twenty-third day of the disease.

Post Mortem Examination.—January 27th. Thoracic viscera perfectly healthy.

Abdomen.—Spleen much softened, and somewhat enlarged; recent peritonitis; much green-coloured lymph effused, gluing the intestines together; pus freely effused in the interstices; slight fæcal extravasation appeared near the termination of the ilium, and a small perforation was found in the intestine three-and-a-half inches from the cœcum.

On opening the intestines, the cœcum was found free from disease, but the ileo-cœcal valve was destroyed by ulceration. The lower portion of the ilium was found full of ulcers of various sizes, some very small, with elevated edges like variolous pustules, others as large as half a crown. In many places the entire thickness of the mucous membrane had been destroyed, and the muscular tunic was extensively exposed. The mesenteric glands were enlarged and diseased. Dr. M'Dowel observed that the specimen admirably illustrated the anatomical characters of "follicular enteritis" (improperly so called), and dwelt upon the peculiarities in the symptoms as contrasted with those of ordinary typhus.

Epithelioma of the Uterus, Stricture of Ureter, &c., &c.

Dr. Banks exhibited the morbid parts taken from a woman, aged 27, who was admitted into the Whitworth Hospital towards the end of October last. She was married, and had borne children. Her health, which was previously good, had become seriously deranged for more than a year. She lost flesh, and laboured under a vaginal discharge, which was occasionally sanguineous; subsequently, she had severe and frequently-recurring hæmorrhages.

When admitted into hospital she presented the appearances with which we are familiar as indicating a state of extreme spanæmia.

Dyspnœa and palpitations were present, and were a source of great distress.

There was no abnormal sound audible in the cardiac region. A loud venous murmur was heard in the neck. The progress of the case was slow, but steadily and uninterruptedly downwards. Pain in the region of the uterus was almost constant, and as the disease advanced, the vaginal discharge assumed a fœtid character. Uterine hæmorrhage to a considerable amount occurred at intervals. During the last few weeks of her life vomiting was almost constantly present, and the fluid ejected from the stomach presented the appearance which is common in malignant disease of that organ. No abdominal tumour could be detected. Uncontrollable diarrhœa existed for some time before her death.

Autopsy.—On opening the abdomen, nothing abnormal was at first observed. The omentum, mesentery, and mesenteric glands were free from disease. On exposing the pancreas, it was found enlarged to about double its ordinary size, and it was much harder than natural; the head of the gland was the part chiefly enlarged; it had contracted adhesions posteriorly of so firm a nature that it was found impossible to remove it without rupture.

The kidneys were greatly augmented in size; the left ureter was surrounded by a solid mass of what appeared to be indurated lumbar glands. There was a complete stricture about three inches and a-half from the kidney, and above the seat of the impediment the ureter was enormously distended, having attained fully the size of the small intestine; its parietes were thickened, and it was rotated on itself.

The right ureter was unusually large throughout its entire extent, but had contracted no unnatural adhesions. The right kidney was large and pale. On making a section of it, the cortical portion could not be distinguished from the tubular, except in one situation, where one or two cones could be recognized. The tissue of the organ was infiltrated throughout with millet-sized spots of a yellow colour.

The calyces were distended, and contained fluid resembling a mixture of pus and urine.

The uterus was enlarged, and a great portion of the os was destroyed by ulceration.

Dr. Lyons examined the uterus and kidney microscopically, and made the following report:—"The affection of the os cervix, and body of the uterus, I regard as epithelioma of a very malignant form, but not cancerous. The microscopic elements consist of cells in great variety of size and form, but, in my opinion, of epithelial origin. The mass which obstructed the ureter or section, gave issue to a substance of the consistence and appearance of dirty white lead; it was composed of cells, and was probably a degenerate gland. The spots in the kidney were small purulent foci, and contained abundant pus corpuscles."

This condition of the kidney is one not often met with, for though renal abscess is not rare, the kidney is not frequently the seat of disseminated pus. In no part of the organ had the purulent points coalesced, and a section resembled somewhat a lung in the third stage of pneumonia. The woman who was the subject of this communication did not die as persons do from effects of retained urea; and this is worthy of observation, inasmuch as one ureter was completely occluded, and the kidney at the opposite side appeared to have undergone almost complete degeneration.

The mode of death differed in no respect from that which is observed in ordinary cases of protracted malignant disease. It may be noticed, that in this case the disease manifested itself at an unusually early period of life.

(*Museum, Richmond Hospital.*)

ASPHYXIA FROM BREATHING THE FUMES OF CHARCOAL; RESUSCITATION FROM APPLICATION OF ACTUAL CAUTERY ALONG THE COURSE OF THE INTERCOSTAL NERVES.

Feb. 4th, at half-past two o'clock, I was called to see a young girl who had just attempted suicide in the above manner. On my arrival, she was laid out on a bed in a large room, with all the windows open—they had just carried her from a small closet adjoining, where one of her friends had found her stretched on the floor, with her head close to a chafing dish, in which some lighted charcoal was just burning out; she had carefully excluded all atmospheric air.

The skin was pale, covered with a cold sweat, and perfectly insensible to the touch; she showed no signs of feeling when pinched, or pricked with needles, or even when lighted matches were applied to the skin. The lips were violet coloured, the hands blue, the pupils were contracted, and remained immovable under the stimulus of light; the nares, dry and pinched, were for a long time irritated in vain with the feather of a pen, and seemed insensible to the fumes of sulphur which had been burned under them; the jaws were forcibly closed—the pulse feeble and compressible, was imperceptible at the extremities; the heart's action was very feeble, and remarkably slow; finally, the respiration, slow and scarcely perceptible, seemed at each instant to become so faint, that several times those who stood around this unfortunate girl thought that all was over.

I immediately opened a vein, the blood flowed slowly at first, then more freely, but soon stopped of its own accord. In the absence of mustard, we applied cloths dipped in boiling water to the extremities, and cold effusions at the same time. Artificial expansion and contraction of the chest was tried, but without success. I then endeavoured to pour stimulants into the throat, but the few drops that did get in were immediately ejected, and it became evident that deglutition was gone, and that the liquid had entered the larynx; all then was in vain. The invincible contraction of the jaws made every effort at artificial respiration useless.

All treatment seemed perfectly useless. The pulse was still very feeble; a bronchitic rale of momentous import began to accompany respiration, and upon examining the chest, we heard all over it the moist rattle which characterizes the last moments of life.

In hopes of exciting some signs of vitality by means of acute pain, I applied along the legs and thighs an iron heated to a high temperature; we might as well have applied it to a corpse. The tracheal rale was now the only sign of life, and I expected each moment to be her last.

I had now been nearly three hours with the patient, and had employed, in vain, every means I could think of. I determined to make one last effort directed towards the respiration. With the point of a hot iron I cauterized the trajet of one of the intercostal nerves; there followed immediately a distinct movement of the ribs, two or three inspirations followed one another rapidly, and the patient, without moving the hands, extended her fingers; a second cauterization determined movements of the hand and fore-arm; and, after a third, the two hands were raised and placed in front of the chest, as if to defend it from the pain. Encouraged by this success, I renewed the cauterizations; I soon perceived that the respiration was accelerated, the patient raised her head and opened her eyes in a staring manner; the pupils were fixed and contracted. She remained thus during one or two seconds. I thought her saved, and left her for a few minutes, but she soon relapsed into her former state, and in a few moments her respiration, pulse, and insensibility were the same as before.

I renewed the cauterization upon the thorax as before, and continued it for a long time. This time the results were still more marked, the patient made a kind of movement to draw up the leg from contact with a heated iron. I then ceased the cauterization, and tried artificial respiration; at the end of a short time, however, she relapsed into coma, and for the third time appeared at the point of death. I had recourse, for the third time, to the cauterization along the intercostal nerves; I applied the iron also to the epigastrium: she was again roused.

I now continued my efforts, and before long I had the happiness to see her attempt energetic resistance. When I was quite convinced that sensibility had returned over her whole body, I commenced to beat her smartly, with a whip with several lashes; at first she remained quite quiet under this, but soon began to give unequivocal signs of suffering. I continued this flagellation for a long time. It was now half-past seven o'clock, when, worn out with fatigue, I was compelled to desist; but the commissary of police, who had witnessed what had passed, and who understood how important for the safety of this woman it was that this treatment should not be discontinued, gave orders for a man to remain, and follow implicitly my orders. At nine o'clock in the evening the organic functions were established—she cried at each stroke, but as we had seen the coma return before, I thought it right to persevere during the greater part of the night; upon the following morning she was in a semi-somnolent state; she answered questions only after being greatly tormented, and then in monosyllables, slowly, and with difficulty. Her state appeared exactly like that of one who had taken an excessive quantity of alcoholic drink.

In the evening her faculties were a little clearer, and the day after, having passed a quiet night, she was completely restored: to our great satisfaction. The patient had no idea of what had taken place; she remembered nothing after the moment when, under the influence of an extremely painful giddiness, she had fallen to the ground from the chair upon which she had sat down to die; she had no distinct remembrance of the burning, nor of the strokes she had received.

This case seems to me very remarkable, inasmuch as this woman recovered from a situation as dangerous as can well be imagined. I feel certain that she would not have lived had it not been for the cauterization along the motor nerves of the muscles of the thorax. The pain appears to me to be a matter no way affecting the success of the plan. Heat in this case acted as an intense excitement in place of galvanism.

We may remark, that the burns on the legs and thighs, though very severe, caused no movement of sensibility; and that the first motion which occurred after the cauterization upon the thorax was a very distinct movement of elevation of the walls of the chest, and, consequently, great dilatation, which again caused a deep inspiration; this movement, repeated several times, brought back the respiration, which relieved the sensorial system, and it was then that the patient became first alive to the pain.

I think the length of time during which the treatment was employed, worthy of remark, even after life, to all appearance, had been established. In several cases which have come under my observation, persons asphyxiated have died, after having in some sort recovered. Similar facts occur in the case of those poisoned by chloroform or opium. It is evident that any violent excitation can for the time overcome the effects of the poison, which, however, when it has deeply affected the economy, is no sooner left to itself than it begins again to produce its accustomed results.

In any form of accidental asphyxia, if the patient still breathes, no matter how slightly, the physician may still have hope. He must immediately have recourse to means with energy and determination proportionate to the severity of the case, and persevere not only till the patient is resuscitated, but till all dread of relapse has passed off.—*M. Faure*, *Gazette des Hôpitaux*, *Feb.* 20, 1855.

DUBLIN: PUBLISHED BY W. B. KELLY,
8, GRAFTON-STREET.
LONDON: S. HIGHLEY, 82, FLEET-STREET.
EDINBURGH: MACLACHLAN & STEWART.
March 1, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1ST AND 15TH OF EACH MONTH.

SENT FREE BY POST.

Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 4.—Vol. II. MARCH 15, 1855. Price 5d.

SIR PATRICK DUN'S HOSPITAL.

Ulcer of the Stomach.

BY ROBERT LAW, M.D.,

PROFESSOR OF INSTITUTES OF MEDICINE AND OF CLINICAL MEDICINE IN THE SCHOOL OF PHYSIC IN IRELAND.

James Farrell, aged 38, clock maker, about five feet ten inches in height, and of a thin, spare habit of body, was admitted into Sir P. Dun's Hospital under my care, April 26th, 1854, when I was about to resign the clinical duty of the hospital to my successor, Professor Osborne. He complained of an almost constant gnawing pain in the epigastrium. He vomited daily a large quantity of a brownish, frothy, yeasty fluid, which had a sharp acid taste. He presented a most marked anæmic aspect, so like a chlorotic female, that I remarked to Mr. Morgan, the Apothecary of the Institution, who was with me at the time Farrell was received into the hospital, I was sure I should find, on applying the stethoscope to the cardiac region, and to the neck, the acoustic phenomena of chlorosis. This conjecture was fully verified, for I never heard a more distinct, soft, bellows murmur replacing the first sound of the heart behind the sternum, nor a better marked *bruit de diable* in the neck. The pulse was extremely weak. His exhaustion was extreme. He did not vomit early in the day. His stomach seemed to retain his breakfast. The vomiting came on almost daily, sooner or later after dinner. He had rather a craving for food, which he expected would relieve the uneasy sensation of the stomach. Careful examination of the abdomen by pressure could discover no tumour in the epigastrium, but only an unusual sensitiveness there. An extended area of tympanitic clearness on percussion intimated an enlargement of the stomach. The fluid vomited was acid, and exhibited under the microscope abundant sarcinæ. The urine was acid; bowels were constipated.

The history Farrell gave of his case was, that until six months previous to his admission into hospital he had enjoyed perfect health. But, that then his illness began, and arose out of the following circumstances:—He had been in the habit of travelling on foot through the country, mending and regulating clocks, nor did he always keep to the road; he sometimes made short cuts through the fields. On one of those occasions, on jumping off a high ditch on the road, he experienced a severe shock, and shortly afterwards discharged from his stomach a large quantity of blood. Soon after this he began to feel pain in his stomach, and vomited not only what he ate, but at other times a large quantity of a brownish, frothy fluid. He also occasionally discharged from his stomach more or less blood. His blanched complexion, and the physical signs of anæmia, and also tinnitus aurium, of which he complained, were accounted for by these hæmorrhages. No doubt, malignant disease has its sallow (subflavus) complexion, as well as anæmia, and both dependent on the altered condition of the blood, still the difference of expression in the two cases generally distinguishes them, the former being that of suffering and distress, while the latter is that of apathy and *insouciance*, or listlessness. Farrell exhibited this listless, apathetic expression, very strikingly—while there was a complete absence of any expression of suffering. Although he was very thin, his emaciation was not extreme, as it is notoriously, at least in scirrhus pylori—and although the bowels were torpid, they readily yielded to medicine. These considerations, coupled with the absence of any tumour in the epigastrium, led us to believe that it was not cancer, and that most probably it was ulcer of the stomach. We believe, pathology is scarcely yet in a position to decide with anything like certainty on the existence of ulcer of the stomach. How often has it happened to us, that the symptoms during life have led us to expect that *post mortem* examinations would find their explanation in this special lesion, when it did not exist, while with equal frequency have we lighted upon the healed ulcer, of whose existence no symptoms during life, as far as we could collect, created any suspicion. How often have the severest symptoms been present during life, when after death we have only found a softened condition of the gastric mucous membrane, with enlargement of the capacity of the organ; whilst again we have in our museum a specimen exhibiting two ulcers of the stomach; the floor of one formed by the pancreas, while the other was connected with the diaphragm, and in which a hæmorrhage from an artery in the pancreas, opened by ulceration taking place into the stomach, produced a violent vomiting, which broke the adhesions that connected the edges of the ulcer with the diaphragm, and thus opened a way for the blood and other contents of the stomach into the cavity of the peritoneum, which soon became the seat of inflammation, that terminated fatally within six and thirty hours. The subject of this case, a French lady, aged about 56, never complained of more than *malaise* in the epigastric region, and drove out in a car the day on which the hæmorrhage occurred. We had a strong impression on our mind that Farrell's case was one of ulcer of the stomach. We directed for him pills composed of three grains of subnitrate of bismuth, and a quarter of a grain of muriate of morphia, to be taken every fourth hour; that he should have nourishing diet, and that his bowels should be relieved by mild enemata. Under this treatment he improved. He now, in consequence of my discontinuing my attendance at the hospital, became Dr. Osborne's patient, which I was glad of, as I knew he took a particular interest in cases of this kind. After remaining about a fortnight in hospital he went out, but re-entered soon after I resumed duty, about six weeks having elapsed since he had been under my care. His condition was very much what it had been before, except that he felt more pain on pressing the epigastrium. He vomited the same large quantity of acid, frothy, brownish fluid, which exhibited abundant sarcinæ; but this vomiting, as formerly, only came on in the afternoon after dinner. He was quite free from it in the forenoon. His desire for food was very urgent. The urine, which was tested on several occasions, was *always* acid. He seldom left his bed, and while there always lay on his left side. He exhibited a peculiar listlessness, and when spoken to answered slowly, as if it were a trouble to him to speak. The pulse was very feeble; the heart also was extremely weak in its action, exhibiting constantly a soft bellows murmur accompanying the first sound heard behind the sternum. Our treatment varied but little, and consisted chiefly of the pills which we have already mentioned, composed of subnitrate of bismuth and morphia, to which also, to relieve the distressing flatulency, we added assafœtida.

The following mixture appeared to relieve the pain and vomiting:—

Infus. menthæ ℥ viridis, viiss.
Liquor potass. ʒi.
Muriatis morphiæ, gr. i.
Aquæ lauro-cerasi, ʒii.
St. coch. ii. ampl. tertiis horis.

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A blister, sprinkled with two grains of muriate of morphia, was occasionally applied to the epigastrium, and apparently with much relief both to the soreness and the vomiting, which sometimes was absent for days. His anæmic aspect and other symptoms, as distinctly chlorotic as we had ever met with in the female, suggested to us the use of chalybeates, and we gave him a mixture of equal parts of mist. ferri comp. and decoct. aloes comp. This mixture seemed to agree with him, at least the cardiac and venous murmurs were less marked; still he did not appear, not alone not to gain more strength, but more life. He retained the same inanimate listlessness of manner. When spoken to he appeared as if he did not hear what we said. His unvarying decubitus was on the left side. The urine was always acid. The brown frothy fluid vomited never failed to exhibit the presence of either perfect sarcinæ or their *debris*. After having been six weeks in hospital he died; life gradually ceased; indeed from the time he came under my care all our endeavours by means of diet and such tonics as I could employ, appeared to produce no other effect than merely to delay the stroke of death. But a most sensible alleviation to his great suffering was effected by the free internal use of morphia, as well as its endermic exhibition. We have ever felt that physicians are too cautious in the use of narcotics, and do not sufficiently appreciate the fact, that pain and suffering engender a remarkable tolerance of this class of remedies; and while we have been thus liberal in their use, in numberless cases when we had no right to expect a cure, we have at least obtained an euthanasia, and have never experienced any injurious results.

Post mortem examination exhibited no organic disease in any organ of the body, with the single exception of the stomach. An anæmic condition alone marked the rest of the body; the stomach was enormously enlarged, and being inflated with air, was almost alone visible on opening the abdomen. We soon found that it was unusually fixed in its position by adhesions that it had formed: it was closely united to the under surface of the left lobe of the liver. That we might examine the parts with as little risk as possible of disturbing them, we did not remove them from the position in which we found them, but made a free opening into the stomach from the great bulging extremity in the length of its superior surface, which discovered to us an enormous elliptical ulcer so situated that half of it was placed on the inferior surface of the organ, and half on the superior. The long axis of the ulcer crossed the long axis of the stomach, and measured six inches in this direction; while its transverse diameter measured three inches. The ulcer, while it engaged all the lesser curvature, involved neither orifice of the organ, each of which lay beyond a point exactly corresponding to its centre. The portion of the ulcer corresponding to the inferior surface was formed by the pancreas, covered by a thin smooth membrane, which allowed the granular surface of the gland to be seen through it, and which formed a kind of pavement, while the portion which engaged the upper surface was roofed, as it were, by the liver covered by this smooth membrane. The margin of the ulcer was formed by a thick band of, apparently, hypertrophied cellular tissue. This indurated structure was most marked where the ulcer corresponded to the pancreas. The portion of the stomach which the ulcer had not invaded was very much attenuated, and had lost its normal consistency. The mucous membrane could be most easily separated in thin layers. We had never either seen or read of, or heard of, an ulcer of such dimensions as this case presented to us. Our museum contains specimens of ulcers of the stomach, in which the liver, and the pancreas, and the diaphragm had each in their turn closed the aperture effected by ulceration; but none could compare in extent with the present one. We have no reason to believe that the subject of this case, as far as we could rely on his account—and he appeared to be a man of sufficient intelligence to entitle him to credit for the accuracy of his statement—we have no reason to believe, I say, that he had any affection of the stomach previous to the period to which he referred it; and if such be the case, we cannot but be surprised at the amount of mischief that took place in a comparatively short time. We have seen years of suffering exhibit infinitely less disease of this kind. We can hardly say that Farrell's case has supplied us with any help towards arriving at anything like a certain diagnosis in this most obscure lesion—although, perhaps, when we reflect on the constancy of his decubitus on the left side, which was so constant that the nurse assured me that she never observed him lying on the right side, and on the tenderness which he ever experienced when the epigastrium was pressed, and see their explanation in the condition of the parts which the *post mortem* examination revealed, the sensitiveness to pressure, and position, taken together, may have some diagnostic value. The cause of the tenderness on pressure is obvious enough, and we presume, the reason of the peculiar decubitus was, that the ingesta were thus removed from the diseased parts, that had acquired an abnormal sensitiveness, for whoever has the misfortune to labour under an irritable stomach, knows well how materially his ease and comfort will be influenced by the position which he assumes in bed—an effect which we attribute to the relation which position produces between the ingesta and a tender spot of the organ; nature ever instinctively suggesting the easiest position. The presence of sarcinæ in the vomited matter aids us but little in our diagnosis, for not only are they found in various morbid conditions of the stomach, but in other organs also; we have always regarded them but in the light of an effect of disease, and not as a cause. The acid condition of the urine was peculiar in Farrell's case; in this respect it differed from what we had observed in other cases, when it was much more frequently alkaline. Dr. Benson Jones has well observed on the relation between stomach affections and the condition of the urine. We are sure the inquiry is one well worthy of the attention of the physician, who wants all the information he can acquire on this difficult and deeply interesting subject. While we must admit, that much obscurity and difficulty still involve the subject of ulcer of the stomach, yet it must be acknowledged that Cruveilhier's observation no longer applies to our knowledge upon it, when he remarks, "ulcère de l'estomac presque toujours confondu avec le cancer de l'estomac et pendant la vie, et même a l'ouverture du corps." We have not generally experienced much difficulty in distinguishing between cancer of the stomach and ulcer; our difficulty has been to distinguish between ulcer and certain pathological conditions of the organ, which we would designate chronic gastritis. We allow that the symptoms of cancer of stomach are very obscure and equivocal, until the disease involve either orifice; then they become plain enough, and render the diagnosis easy; but until then they are much less felt by the patient, and less appreciable by the physician, than are the symptoms of ulcer. We have seen *post mortem* examinations discover cancer of the stomach which was not suspected during life: and we have a specimen of cancer extending from the stomach into the œsophagus, the subject of which was considered to labour only under disease of the heart; the disease of the stomach had existed for a considerable time before it involved the cardiac orifice, and then exhibited no palpable sign of affection of this organ; but when it reached the œsophagus, the difficulty of deglutition at once threw light on its real nature. The supposed heart disease was nothing more than a functional disturbance of the organ dependent upon the diseased stomach. As far as our observation has gone, we believe that moral influences are strong predisponents to cancer of the stomach, while we do not think they are in any way connected with, or lead to, ulcer of the stomach.

REMARKABLE CASE OF CANCEROUS DISEASE DEVELOPED THROUGHOUT THE OSSEOUS TISSUE.

BY R. W. SMITH,

PROFESSOR OF SURGERY IN THE UNIVERSITY OF DUBLIN, SURGEON TO THE RICHMOND HOSPITAL.

Although a considerable period has now elapsed since the following case came under my observation, I, nevertheless, deem its history not the less worthy of being detailed, inasmuch as it furnishes an example of a far more general diffusion of cancerous disease throughout the osseous tissue, than any that has hitherto, I believe, been placed upon record.

The patient was a female, æt. 63, of sallow complexion and a very unhealthy appearance. Four years before her death, and eight after the catamenia had ceased, she began to suffer from lancinating pains in the left breast, and a small, hard tumour formed near the nipple, and very soon became adherent to the skin, was uneven upon its surface, and after some time the axillary glands became enlarged and indurated. The tumour underwent no further changes for two years and a-half, when a scab formed upon its surface, upon the separation of which a very superficial ulcer, not as large as a shilling, remained: this sore never increased either in extent or depth, and yielded but little discharge. In fact, during the remainder of her life, the diseased breast attracted no share of her attention, and the lancinating pains, which were at first experienced, latterly ceased altogether. Severely, however, and almost unceasingly, did she suffer from pains, which she conceived to be of a rheumatic character, in all her bones; she had cough, and pain in the right side; her appetite failed, her sleep deserted her, and her flesh wasted away: she was for a long time before her death completely bedridden; she could not endure that any one should touch her; and her efforts to move herself in the bed were, upon several occasions, followed by fracture. She died, exhausted by pain and suffering, and in a state of complete emaciation.

The *post mortem* examination, which I conducted with the greatest care, proved most interesting, and revealed an immense extent of cancerous deposit, limited to a single system; for, with the exception of a tubercle, about the size of a small nut, in the liver, the organs, in all the cavities were perfectly healthy; while, upon the other hand, nearly the entire of the skeleton, from the head to the feet, was pervaded by cancer.

In the anterior part of the frontal bone, there existed a firm, white, elastic tubercle, of the size of a nut, in the diploe: it had absorbed both tables, and penetrated the frontal sinus, through an opening in its posterior wall. A second and much larger mass existed more posteriorly, which had separated the inner and outer tables widely from each other; reduced them to an extreme degree of tenuity, and, in some places, totally absorbed them, and in such situations, the pericranium and the dura mater formed the immediate coverings of the tubercle: both these membranes were healthy. In several situations, the frontal and parietal bones were discoloured, and presented a slightly corroded aspect; and through all parts, so altered, the scalpel could be passed without difficulty into the brain; and when the calvarium was removed, the corresponding parts upon the internal surface of the bones were found similarly discoloured, and raised slightly beyond the level of the surrounding bone. The cancerous deposit had, likewise, perforated the occipital bone, and absorbed a portion of the petrous process of the temporal bone.

The left clavicle was fractured external to its centre, and the interior of the bone was occupied by scirrhous matter from its sternal to its acromial extremity.

The left humerus was broken in its centre, and the cancerous deposit filled the medullary canal from the head of the bone down to its lower extremity.

The right femur was fractured at the junction of its upper with its middle third: a longitudinal section of the bone exhibited a fine example of carcinoma occupying the cancellated structure and medullary canal. A large, circular, scirrhous tubercle was seen in the very centre of the head of the bone; another existed in the cervix, while from this down to the lower third of the shaft, the cancerous matter was deposited in one continuous mass: the compact structure became gradually thinner as it approached the seat of fracture, and a circular perforation had been produced by the tubercle which occupied the head of the bone.

In the left femur, the ravages of the disease were even more extensive than in the right: the cervix was broken, a considerable portion of it absorbed, and the remainder occupied by a mass of scirrhous structure, which was also copiously deposited throughout the remainder of the bone, which, near its centre, was perforated by one of the tubercles.

There were no tubercles in the bones of the leg, but the medulla presented a most unhealthy appearance and colour, and its consistence was totally different from that which it possesses in the normal state.

The ribs contained numerous deposits of scirrhus in their interior, and several of them were fractured.

The disease occupied the spinal column from the lower part of the cervical region to the sacrum; the cancellated tissue of the bones had disappeared, and its place was occupied by a firm, elastic, scirrhous structure of uniform consistence, and of a roseate hue; there were here no separate tubercles, one mass of the morbid deposit filling the interior of the body of each vertebra, and in many places the compact structure of the posterior surface of the bones had been destroyed. The laminæ of the vertebræ and the spinous processes had undergone the same carcinomatous degeneration, and the vertical extent of several of the dorsal vertebræ was much diminished, some of them not being more than half an inch in depth.

The bones of the pelvis were entirely converted into a scirrhous structure. The ilium was perforated by large circular tubercles, which were in contact with the periosteum of the iliac fossæ, and in some situations the carcinomatous matter was deposited in a continuous sheet throughout the diploe. The ischium and pubis, which had suffered an analogous degeneration, were both fractured, and the morbid growth had even made its way into the acetabulum.

The characters of this heterologous deposit were precisely the same in all the affected bones; it was white, firm, tough, and dense in its texture, highly elastic, and cut like cartilage; it in no respect differed from true scirrhus as it is seen in the female breast. The osseous tissue in contact with it had suffered no alteration but such as resulted from absorption.

The preceding case furnishes the most remarkable instance with which I am acquainted, of cancer of the bones, a disease, many points in the history of which are surrounded by difficulty and involved in obscurity, notwithstanding the elaborate nature of the investigations to which it has of late years given origin.

Using the term in its widest acceptation, we meet with cancer in the osseous system under several forms, and a great variety of circumstances: it occurs either as a primary or secondary disease; we see it limited to one bone or invading many, either simultaneously or in succession; we find it either with or without profound modifications in the osseous structure in contact with it; it is seen with tumour external to the affected bone, or the latter may preserve to the end its normal form and outline; it may invade the bone from its periosteal surface or perforate it from within; it may present every variety of colour and consistence.

It is by no means my purpose, at present, to consider the disease under all these different circumstances; on the contrary, I wish to limit my observations to the affection as it presents itself in the remarkable case which has been detailed.

We have here an example of the deposition of scirrhus in the osseous tissue, an occurrence which has been denied by a recent and distinguished writer:—"Il est à remarquer que le tissu sqirrheux qui se trouve fréquemment dans les autres tissus ne se montre pas dans les os."* It does not, it is true (although the contrary is stated by Cruveilhier), occur as frequently as some of the other forms of malignant disease, but, nevertheless, I have seen several examples of it, and I may remark that in many striking features it differs from the encephaloid tumour of bone; for instance, it is very seldom, indeed, that the scirrhous tubercle passes the level of the surface of the bone in which it has been deposited; nor has my experience furnished me with any example in which it formed a tumour obvious to the eye, no matter how superficially placed the affected bone may have been; while, upon the other hand, the growth of the encephaloid tumour is almost unlimited.

Again, the true scirrhous tubercle does not convert the bone into its own tissue; it is not found to contain osseous spiculæ; it produces no organic change in the bony structure by which it is surrounded, which is simply absorbed "molécule par molécule," until what is termed spontaneous fracture takes place, and in some cases this is the first and only indication of the presence of so formidable a disease in the osseous system.

Moreover, I have never seen the scirrhous tubercle confined to a single bone, on the contrary, it usually invades a large portion of the skeleton; nor have I observed it independent of cancer in some other part of the body; but with regard to the encephaloid disease, although frequently it attacks several bones, yet frequently also, it exists in one alone, and without any other organ or structure being affected with malignant disease.

It will be understood that in the preceding remarks I make no allusion to what some have termed cancerous infiltration of bone, a form of disease marked by pathological phenomena, totally different from those which characterize the scirrhous tubercles, and in which the osseous structure seems to suffer a genuine atrophy, both of its earthy and organic constituents.

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* Nelaton, tome ii.

In the case which has been described, there is nothing more remarkable than the universality of the deposit, the complete cancerous infection of the skeleton, and this associated with so trifling an amount of malignant disease in other parts. I can offer no explanation of this singular preference shown so frequently to the osseous system in cases of mammary cancer, which, indeed, appears to possess, in a higher degree than cancer of any other structure, the power of contaminating the whole economy.

Lebert found the osseous system diseased in fourteen, out of twenty-three, cases of cancer of the breast. I have never found any of the bones affected with scirrhus in cases of uterine cancer, but Cruveilhier has recorded an example of this disease, in which the frontal bone was perforated by a scirrhous tubercle developed in the diploe, and also one of cancer of the stomach, in which tubercles were deposited in the humerus, leading to the fracture of the bone. The results, however, of my own experience, agree with those of Mr. Stanley, who states that he has never seen hard cancer in bone as a primary disease, or in any cases where the primary cancer was situated elsewhere than in the mammary gland. It is, of course, true, that malignant disease frequently affects the osseous system primarily and solely; but in such cases the morbid growth assumes the form of cephaloma, osteosarcoma, &c., &c.

It has been in the very chronic forms of cancer of the breast, that I have most frequently seen the osseous system generally infected by scirrhus; but I had lately under my care in the Richmond Hospital a case where the mammary cancer was of rapid growth, and in which severe pains in the long bones and in the vertebræ left little doubt on my mind of their being contaminated by the disease.

When situated in the diploe of the bones of the head, the scirrhous tubercle generally destroys the internal to a much greater extent than the external table, but it seldom passes the level of the bone, nor have I ever seen it produce symptoms of pressure on the brain, or of irritation of the membranes.

The class of diseases of the osseous system to which the case which I have detailed is to be referred, constitutes a subject surrounded by difficulty and much obscurity, and most important in its pathological and practical bearings, but one upon the consideration of which it would be impossible to enter at present; but I hope, upon some future occasion, to have an opportunity of discussing fully the entire subject of the malignant tumours of the bones.

HARDWICKE HOSPITAL.

Clinical Remarks on a Case of Puerperal Peritonitis, &c., &c.

BY SAMUEL GORDON, M.B.,

PHYSICIAN TO THE WHITWORTH AND HARDWICKE HOSPITALS.

Among the many cases of diffuse inflammation which present themselves to our notice in these hospitals, we have not often an opportunity of seeing one connected with puerperal fever. The following case presents some features of interest connected with this terrible malady:—

Reported by MR. ABBOT, *Resident Clinical Clerk.*

Anne Jordan, æt. twenty-one, was admitted into the Hardwicke Fever Hospital, January 25, 1855, with the ordinary symptoms of fever. She suffered at first from headache, sleeplessness, intolerance of light, and other symptoms of cerebral excitement, which were, however, early subdued, and she appeared convalescent and was anxious to get up on the eleventh day of her illness. Her subsequent recovery was very slow and tedious and unsatisfactory. On Feb. 13, she complained of "rheumatic pains" affecting her left shoulder, side, and hip; these were succeeded, on the following day, by a general feverishness; her tongue became thickly coated, her pulse rose above 100, but was feeble and compressible, her skin hot; her face slightly flushed, and a herpetic eruption appeared on the upper lip. These symptoms commenced with a rigor, and were followed by pain and tenderness of the abdomen, and the other usual symptoms of peritoneal inflammation.

Feb. 15.—The general soreness and pains were diminished, but appeared to have centred in the left hip joint: the next day she was prematurely confined of a seven-months' child. Her accouchement was very easy; she suffered no pain; there was then an interval of about thirty-six hours, during which there was almost perfect cessation from all pain and suffering, the abdomen, however, continued swollen and tympanitic, and painful on pressure.

After this interval the other symptoms of puerperal fever recurred with increased severity; her countenance became indicative of great suffering; her pulse rose to 140, and she had constant hiccough.

Feb. 19th.—She gets no sleep; is constantly moaning with pain; her tongue is dry and brown; her face at times flushed, undergoing frequent alterations, but always anxious and expressive of pain; decubitus on back, and suffers great pain when any attempt is made to move her; the right elbow is swollen, painful and of a dusky red colour. There is also a small patch about the size of a sixpence on the forearm, and one of the small joints of the opposite hand is also affected. She was rapidly seized with effusion into the bronchial tubes, and expired on the 20th.

This case presents some features of great interest. First, with regard to the time at which the disease appeared. It is very rare, indeed, for the symptoms of puerperal fever to become developed before delivery, as they clearly were in the present instance. Copland refers to three or four such cases which he saw in consultation; and he states, that in two instances it either followed or caused abortion, he does not determine which, but thinks it probable that the abortion was the result of local infection.

The symptoms of this formidable disease vary according to the period at which they occur; and the prognosis is more favourable in direct proportion to the length of time which has elapsed between the actual delivery and their accession. Thus, in two well-marked cases of this disease, which I happened to see in the present epidemic, the symptoms commenced in one on the twelfth and in the other on the fourteenth day, and they both made a perfect recovery. Dr. Ireland saw the latter case with me on several occasions. I believe, however, that there are no recoveries among the few, fortunately very few, cases in which the symptoms of puerperal fever are developed before delivery.

The *post mortem* examination in this case was conducted with great accuracy by my friend Dr. Barton, particularly with regard to the uterus and uterine appendages.

There were found the usual anatomical evidences of acute pleuritis of the left side, also serous effusion into the cavity of the pericardium, and a great quantity of soft greenish lymph and sero-purulent matter was effused over the anterior and upper surfaces of the uterus, and into the true pelvis; more sparingly through the remainder of the peritoneal cavity. The interior of the uterus was of a very dark colour, and seemed in a very sloughy condition, but the veins did not contain any evidence of inflammation. This freedom from phlebitis, at least as the primary source of the disease, we might naturally have expected, when we considered how it commenced, before there was any exposure of the internal surface of the uterus. We are not, in all cases, to imagine, however, because the usual anatomical appearances of uterine phlebitis are not found, that the veins did not convey purulent matter into the circulation: it is perfectly possible that other local inflammations may be set up in this way, although the uterine veins themselves present no appearance of inflammation.

This fact is otherwise of interest, inasmuch as I am informed by my friend Mr. Richardson, who has conducted a great many *post mortem* examinations of this disease during the present epidemic, that this is the usual *post mortem* appearance, perfect freedom from inflammation in the veins of the uterus or its appendages; in fact that this condition was only found in one of the numerous examinations made by him.

AN ESSAY ON THE QUESTION OF CONTAGION IN YELLOW FEVER.

BY WILLIAM J. CUMMINS, M.D., &c.,

PHYSICIAN TO CORK DISPENSARY, CIVILIAN SURGEON IN CHARGE OF THE DEPOT HOSPITALS IN CORK GARRISON, LATE SURGEON OF R. M. COMPANY.

[Read before the Cork Medical and Surgical Society, December 27th, 1854.]

(*Continued from page 42.*)

I am sure you will agree with me in considering that these cases of Sir William Pym's afford much interesting and instructive matter, as regards the natural history of the epidemic yellow fever. But I think they fail in affording evidence of its possessing a reproductive power.

In order to explain my reasons for taking a view of them so contrary to the opinion of the author, I shall classify them, and treat of them under four heads, which will embrace all the evidence brought forward.

1st. Evidence afforded by the fever having been introduced by diseased individuals into a healthy town, district, or ship, and a subsequent outbreak of the disease among their new neighbours.

Yellow fever, although an epidemic disease, differs from the ordinary fever of this country, as well as from small-pox and the exanthemata, in never becoming truly endemic; like cholera it occurs in fearful epidemic paroxysms, but between these paroxysms there is an interval of perfect health. Consequently, whenever an individual arrives in a town or district, and dies of yellow fever, we may be sure that an epidemic influence, whatever that may be, is hanging over the place he has arrived from, which cannot be far remote; further, we know enough of all epidemics, to be aware that they travel about with remarkable celerity from one country or city to another, so that the very fact of Spain containing yellow fever, affords a presumption that Gibraltar will not escape.

Suppose an admittedly non-contagious disease suddenly broke out in England, would we not tremblingly expect it in this country, and if it did subsequently appear amongst us, could we not easily pick out instances of communication cotemporaneous with the outbreak, and found upon them a "*post hoc ergo propter hoc*" argument?

I have already shown that no argument can be drawn from the fact of Gibraltar continuing healthy while quarantine was in exercise, and prevailing on its removal, by an admission of Sir William Pym's, that the quarantine was broken, in at least one instance during the time referred to, and you will remember that I have quoted several other instances of breach of quarantine in Ascension, Fernando Po, &c., so that these precautions are not to be depended upon for excluding even a contagious disease, as they are almost always broken. These remarks are equally applicable to the cases brought forward by Sir William, of persons carrying the disease on board ship, for all his recorded embarkations occurred in infected harbours, with one exception, that of the "Bonetta;" she received the infected prize crew from the "Forrester" at sea, where the surrounding atmosphere was not likely to have been tainted; consequently, the cause of her attack must have been her communication with the "Forrester," unless she had the poison previously on board in a dormant state, which I think is rendered probable, by the fact that she had only a week previously left Acra, an African port, not far from Sierra Leone, where the "Forrester" herself received the disease; and it is well known that yellow fever often does not appear in a ship for several days after leaving the port where she had received the poison on board.

Sir William Pym mentions instances of this kind, and I have myself been witness to many such.

2nd. Evidence afforded by removal from infected localities being followed by a speedy cessation of the disease.

The cases which come under this head are about the most interesting in Sir William Pym's book, as they prove in a most decided manner the existence of that mysterious attribute of the epidemic poison of yellow fever which it seems to share with cholera—I mean, a capability of concentrating itself in certain spots, leaving others, and often neighbouring ones, in comparative or entire freedom from its influence. It seems as if the poison, whatever it is, can be attracted and retained by certain terrestrial peculiarities, such as large deposits of coal, &c., which, however interesting, is not a part of our present subject, except in so far as it explains the exemption of soldiers when removed to camp, &c., &c., without reference to contagion.

It is sufficiently proved, that removal from the focus of contagion was not the cause of the cessation of the disease among the soldiers who were removed to the neutral ground at Gibraltar, because they carried the focus of contagion along with them in the shape of their hospital establishment; and, besides, several new cases occurred shortly after removal, from the disease being dormant in their systems; so that every way they had contagion (if the disease be contagious) amongst them.

The same facts may be mentioned of the other cases of this kind, quoted from Sir William Pym; such as the removal of the troops from the transports to hulks in Gibraltar Bay, &c.

3rd. Evidence afforded by the fact of individuals who embarked on board the "Eclair," in Madeira and England, having been attacked by the fever then raging on board her. If it was not an established fact, that the epidemic poison of yellow fever has a power of localizing itself in certain spots, and especially on board ship, such cases as these would be proof positive of its being contagious; but in the present state of our knowledge they can only be regarded as proving either contagion or localization, and as the former is at least a doubtful phenomenon of the disease, and the latter an admitted one, a rational reasoner should prefer an explanation of such facts based on the certainty.

It may be said, that a poison can scarcely continue localized on board a vessel at sea, which is continually changing its atmosphere. It is a mistake, however, to suppose that the interior of a ship is much, if at all, more favourably circumstanced for getting rid of impurities than any ordinary dwelling. If currents of air were continually circulating between decks, a vessel would scarcely be habitable; besides, there are holes and corners of every ship which, having little or no communication with the general atmosphere, may be capable of continually resupplying the better ventilated parts with poison. Why should not a ship be capable of retaining an epidemic in the same way that families can retain a contagious poison?

We know that many principles, powerful for good and bad, are independent of the wind—I would instance electricity; so that till we can solve the problem, what is an epidemic poison, the full explanation of many of its well ascertained phenomena must remain, to a certain extent, veiled in obscurity.

4th. Evidences afforded by an outbreak of the disease, following upon the arrival in port of an infected vessel. I have quoted five instances of this kind from Sir William Pym—those which he refers to in his preface as being the very best proofs of contagion—and mark! in four out of these five the disease broke out in defiance of quarantine of one kind or other. To be sure, in one of them the isolation was broken by a soldier's wife having washed clothes for a sailor of the infected ship; and in another, Sir William Pym "*was told*" that the clothes of an officer, who had died of the fever, were sold in garrison; but in the remaining two no communication could be traced, though, of course, eagerly sought for.

Again, Sir Wm. Pym says, in the beginning of his book—I quote his words:—"The fourth day was generally the period of incubation; and this was ascertained most positively in innumerable instances."

Now it is remarkable that in three out of the five cases we are treating of, the disease appeared a month or more after the arrival of the infected ship. Let us couple these inconsistencies:—

1st. With the probability that a constant communication was taking place between the diseased and healthy ports mentioned, in the ordinary course of commerce, as well as by means of the man-of-war cruizers, which are the subjects of these remarks;

2nd. That their geographical position is not very far remote from each other; and—

3rd. That epidemics, whether contagious or not, are known to travel to neighbouring places independently of contagion; then we arrive as nearly as possible at a certainty, that the outbreak of yellow fever in Ascension, Fernando Po, &c., had no connexion with the arrivals which preceded it.

I have now laid before the Society a sufficient number of facts bearing on both sides of the question to justify the expression of an opinion one way or another. Let us recapitulate the points we have arrived at:—

1st. That yellow fever may be introduced continually into many of its accustomed localities, without such importation causing either a partial or general spread of the disease.

2nd. That on taking an author who, from his position, had access to the best information on the subject, as the representative of his party, and weighing well the facts to which he directs most particular attention, as being decided proofs of contagion, we find that his conclusions can all be explained away by reference to well known epidemic laws, or to inaccuracies in description, which can be detected by comparing one part of the book with another.

3rd. That a solitary instance bearing in favour of contagion has been mentioned—that of the transfer of the prize crew from the "Forrester" to the "Bonetta," followed by spread of disease on board the latter; but that as we are not informed whether yellow fever was at Acra, which she had left the week before, and as the probabilities are in favour of its having been there, a gap occurs in the history, which prohibits our drawing any conclusion from it, more especially as it stands in solitary opposition to a host of contradictory evidence.

4th. That quarantine regulations are unable to exclude yellow fever.

5th. That yellow fever may spread epidemically to a country, which had previously received a constant importation of it without suffering.

The evidence afforded by the facts contained in this essay, when taken together, is, therefore, decidedly against contagion. It is quite impossible to prove definitely that any disease is not contagious; the most such a subject admits of is a strong probability founded upon numerous negative facts, and the absence of a single affirmative one. And such we have now arrived at as regards yellow fever, from a study of its history; and the position thus obtained is, I think, strengthened by reference to its pathology, for although it is quite a distinct disease from the intermittent, the bilious remittent, and the continued fevers of marsh origin, it evidently belongs to the same class if its poison operates primarily on the nervous system.

I shall not now enter into my reasons for believing in the latter hypothesis, but permit me to refer to a paper of mine in the first volume of the DUBLIN HOSPITAL GAZETTE, where some of them are to be found.*

There can be no doubt that the blood becomes sooner or later diseased during the course of yellow fever; but that disease seems to be an effect of the primary disease of the nervous system, and, as such, does not contain the elements of yellow fever (in other words, its poison), which consequently cannot be thrown off by excretion; this is further proved by the fact that black vomit has been drunk, and, I believe, inoculated, with impunity.

Epidemic poisons, which operate primarily on the blood, can be reproduced by some process, perhaps analogous to fermentation, and most of them are contagious; but those which operate primarily on the nervous system cannot have that power; consequently we find that diseases of the nervous class are not considered contagious, except possibly by irritation.

Before I conclude, I wish to make some allusion to the opinion of a moderate section of contagionists, who include some eminent men in their ranks; they say that yellow fever, though not contagious where an epidemic poison is absent, is decidedly so during its existence.

I cannot understand such a dogma; for to be contagious the noxious material which gives origin to the disease must be capable of reproducing itself in the system, so that when the reproduced particles are thrown off by the excretions, they must be *identical* with the poison originally introduced. Now, if they be identical with it, they must have the same power as it possessed of producing disease, whether the epidemic poison is present or not. In fact, an admission that a disease is ever contagious involves the further admission that it possesses a power of forming a local poison around each individual who becomes its subject.

I hope the Society will pardon the imperfections in this paper, and attribute them, in some measure at least, to the increased difficulty of the task imposed upon me by not having been witness of the facts, which appeared to bear against the opinion which my personal experience of yellow fever had led me to form.

In conclusion, I would say, that if at any time a vessel should arrive in our harbour with yellow fever, I trust the Society will oppose the adoption of quarantine measures, which not only interfere with commerce, but, by keeping a number of persons shut up in a localized yellow fever poison, increase its fatality.

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* Vide Vol. I., page 150.

CASE OF ABORTION.

BY WILLIAM REID, M.D.

A lady, while riding on Killiney Strand, was thrown from her donkey with some violence; the shock passed off after a short time, and no more notice was taken of it for four days, when a bloody discharge appeared, which she looked on as the catamenia appearing a little before the usual period; it continued for five days, gradually increasing in quantity, but on the sixth day it became actual flooding, and to such an extent that fainting was induced. I saw her on the sixth day, and found her very weak, cold, pale, with a small, thready pulse: she positively asserted she was not pregnant. On examination, I found the os uteri scarcely dilated, quite soft and patulous, and could not detect anything presenting, like a fœtus, or tumour. On the seventh, and for thirteen days after, the discharge continued, sometimes to such an extent that I greatly feared loss of life would be the result, a gush of blood, amounting to a pint, occurred three or four times a-day: she had faintings three or four times each day.

On the fourteenth day from the time I first saw her, I detected the hand and arm of a fœtus presenting, which I was enabled to extract with difficulty, as the os was still very slightly dilated (the fœtus was about three months old). After the extraction, a great quantity of blood was lost; but on the membranes being removed, the discharge gradually ceased, and she made a very slow recovery, being unable to bear removal to her town residence for a considerable time.

There are three remarkable circumstances connected with this case: first, her not knowing she was with child, though she had five children previously; this may be accounted for by her not this time having the usual symptoms of morning sickness, loss of appetite, &c., which she always had; secondly, the catamenia appeared regularly every month, which she said was her reason for so positively asserting she was not pregnant, as it never appeared with any of her other children; and the last remarkable fact is the very great loss of blood, coming on so often without pains, and continuing so very long, particularly as the term of gestation was so short. She is tall and slightly made, such a person as would not be expected to bear so great a loss of blood. I am satisfied her highly cultivated mind and great moral courage were a principal means of saving her life, as they enabled her to bear up against the great shock which her constitution underwent. The treatment consisted of as much stimulants and nourishment as she could take, with cold applied to the spine, loins, and abdomen, plugging the vagina, small doses of ergot, cold water enemata, keeping the room very cool and well ventilated.

She is now quite well, and able to live as usual.

PATHOLOGICAL SOCIETY MEETINGS.

February 3rd, 1855.

MR. FLEMING, IN THE CHAIR.

Retro-Peritoneal Cancer.

DR. STOKES laid before the Society the morbid parts, illustrative of retro-peritoneal cancer, taken from the body of a man who died in the Meath Hospital on the previous day, and made the following observations on the case.

The patient, as far as we know, has been subject for about two years and a-half to a wasting diarrhœa; but we cannot say what was the nature of his first attack. He came into hospital under the care of my colleague, Dr. Lees, in the early part of last spring. At that time he was greatly emaciated, and had been nearly a year labouring under the diarrhœa. He exhibited all the symptoms of extreme anæmia: he was colourless, and singularly white—to a degree that I do not remember to have seen equalled even in young females. He had also a venous murmur in the neck, and a murmur in the carotids, and these were accompanied with a doubtful venous pulsation. The patient presented also at the heart a loud bellows murmur, which predominated at the apex, and diminished towards the base of the organ. This bears directly on the question of diagnosis between organic and functional disease, and is on that account a point of great interest in the case. The abdomen was slightly enlarged. I did not see the patient at the first period of his admission, but when he came under my notice he had ascites, and I am inclined to think there was abdominal effusion throughout. He complained of pain under the false ribs, and on examination a tumour could be detected under the margin of the liver. This tumour was very variable, both with respect to size and to the ease with which it could be felt: these circumstances evidently depending on the condition of the intestines. During the whole of the long period in which he was in hospital, there was scarcely any change either in his symptoms or in his appearance. After repeated examinations of this man, I came to the conclusion that he was labouring under cancerous disease. He had certainly no external appearance of this affection; but he had that collection of symptoms which lead to the diagnosis of cancer. In the first place, the diarrhœa had resisted every attempt which could be made to check it; and, though the stools were diminished for a time, they afterwards returned, and were established with the same persistence as before, which indicated that the cause of it was owing to some organic lesion. We felt satisfied, too, that the tumour in the abdomen was not a tumour of the liver: for, between the tumour and the natural situation of the edge of the liver, there was a deep sulcus to be felt. As the disease proceeded, the finger struck down on a tumour of extreme hardness, and at one time it was considered whether this might possibly be the liver in a state of cirrhosis. We concluded against this, first, because we had ascites preceding the existence of the tumour; and secondly, I was led to the opinion by the recollection that in the great majority of cases we have enlarged spleen; but we found no enlargement of the spleen in this case, and, therefore, we concluded that the ascites was not the result of cirrhosis. Having then a hard tumour with ascites, but no enlargement of the spleen, we came to the conclusion that it was a case of cancer.

I may now mention another circumstance in connexion with the circulatory system. The bellows murmur, which was well marked last summer, latterly disappeared, so that the heart's sounds were presented without murmur. The *bruit* in the carotids had likewise ceased; but I am not prepared to say that the venous murmur had entirely disappeared; with respect to the state of the heart, however, there is not the least doubt. Now, presuming the murmur to have been anæmic, while the original cause of disease went on increasing, the question arises why the murmur should have disappeared when the patient was every day advancing in disease.

On opening the abdomen, we found that the peritoneum contained a large quantity of serous fluid. The deposit which you see here appears to be that form of cancer described by Lobstein, under the name of "nodulated," and which is formed in the retro-peritoneal cellular tissue exclusively, and infringing little on other parts. In this case we find it converting the cæcum into a hard irregular mass, but the intestinal canal is perfectly pervious. The term nodulated is very well applied to this form of cancer. The scirrhous masses are of great hardness, and fixed in the omentum, and of various sizes, from that of a grain of duck shot to that of a bean; you see them in some places forming grape-like clusters, and all in the retro-peritoneal tissue. A very interesting fact, to which I beg to draw attention, is, that while there was this mass of disease in the cæcum, the ileum leading down to it, so far from being dilated, was the most narrow and contracted ileum I had ever seen, and was not, in fact, large enough to admit anything bigger than the little finger of a child. The mucous membrane of the colon presents a singular appearance. It is mottled with dark lines running in a transverse direction, and is marked by numerous white lines; while at the same time it has a gelatinous appearance, and seems as if portions of it had been the seat of old ulcerations which have cicatrized, without having been afterwards provided with villi. On pursuing the examination, we found the spleen extremely small, and a mass of cancer just at the insertion of the vessels pushing the organ before it, but the spleen is itself healthy. The same thing occurred in the liver. The lungs were free from disease, and the kidneys presented a similar condition with that of the other organs of the abdomen.

The last observation which I shall make is in connexion with the state of the heart. There is no valvular disease, and I had no reason to doubt at first that the murmur in the heart was anything but anæmic, but so far from predominating at the base, it predominated at the apex. It is asserted that murmurs at the apex occur only in connexion with organic disease. I have long believed, however, that this doctrine is not to be trusted, and this case illustrates the correctness of that opinion, for here we had functional murmur occupying the same situation in which it is found in mitral disease. The heart, moreover, is contracted on itself, and very small. I think it probable that this condition of the heart existed for a considerable time before the patient's death, and was the mode which the heart took of adapting itself to the diminished stream of fluid it had to transmit. Can it be that to this concentric hypertrophy, which the heart has undergone, the loss of the murmur is due. If this be so, it is a new fact in the history of anæmic murmurs, and a point of no small interest in cardiac pathology. The heart appears to me to have adapted itself to the diminished quantity of blood it had to discharge; and the fact itself throws considerable light on Dr. Corrigan's theory, which attributes anæmic murmurs to flaccidity of the vessels.

Fœtid Abscess of the Lung, from Presence of a Foreign Body.

Dr. Hughes exhibited the trachea and lungs of a patient, who was admitted into Jervis-street Hospital five weeks ago, complaining of great debility and constant cough, which was attended with fœtid expectoration. He was generally wasted; had almost complete anorexia, a rapid feeble pulse, and night sweats.

Anteriorly the physical examination gave comparative dulness over the left side, with resonance of the voice, and bronchial breathing at the apex of the lung. Posteriorly there was muco-crepitating râle from the angle of the scapula to the base. The right side was normal.

The crepitating râle disappeared in some days. But there was no improvement in his symptoms, and little change in the physical signs, until ten days before his death, when well marked signs of a cavity under the left clavicle were present.

From that period the expectoration became more profuse, and he rapidly sank.

On a *post mortem* examination we found adhesion of the pleura around the apex of left lung. This portion was solidified, and contained a cavity in which was found a small fish bone. (Dr. Hughes then showed a fish bone about one inch and a-half long, sharply pointed at one end, and curved. It was one of the bones of a plaice.) The cavity also contained some purulent matter, and communicated with several others which penetrated through the centre of the lung to its base.

The right lung was healthy: there was no trace of tubercle in either. The mucous membrane lining the trachea and left bronchus appears of a dusky red colour, and is softened. The œsophagus is perfectly healthy, and all the other organs were found in a normal condition, save the liver, which was large.

Extra-Uterine Conception.

Professor R. W. Smith gave a brief account of a case of extra-uterine pregnancy, and exhibited the specimen. The subject of the case was a negress, æt. 30, in the Island of Tobago. She got into a quarrel, during which she received a blow with a stick across the shoulder, but sustained no other injury. She almost immediately became weak and faint; sunk into a state of collapse, and died in a few hours, with symptoms of internal hæmorrhage.

Upon examining the body, the abdomen was found to contain a very large quantity of blood; the source of the hæmorrhage was traced to an extensive laceration in what at first sight appeared to be a tumour, about as large as a small apple, connected with the uterine appendages, but which proved to be a sac, containing an extra-uterine fœtus in about the seventh or eighth week of its development. The results of a careful dissection of the specimen (made by Mr. Connor, curator of the Anatomical Museum of Trinity College) showed that the sac was formed by a dilatation of the outer part of the Fallopian tube.

From the junction of the outer with the middle third of the tube, a thin but strong band of membrane, like a piece of thick thread, passed to the ovary, to which it was firmly adherent; the Fallopian tube, at the point of attachment of this abnormal band, was drawn towards the ovary, so as to form an acute angle, and here the canal was obstructed. The outer portion of the tube thus became dilated into a sac, in which the fœtus was developed; the rupture of the sac was fully two inches in length.

EXTRACTS FROM REPORTS OF LONDON MEDICAL SOCIETIES.

On Perforating Ulcers of the Stomach. By Mr. Sedgwick.—After briefly alluding to the labours of others in the same field of observation, the author stated that it was his intention to restrict his remarks to such points of interest connected with the disease as he was enabled to illustrate by recent cases, of which he exhibited five *post mortem* preparations. Some of these would be found to contain facts which were probably new, and might consequently interest, from their novelty; but in directing the attention of the Society to them, he (Mr. Sedgwick) was more anxious to dwell upon such points as should be considered practically useful, rather than such as might be thought to possess the attraction merely of being new. The author observed that the immediate cause of these ulcers was still involved in obscurity, and that much patient inquiry, especially by means of the microscope, would probably be required, before we could hope to arrive at any definite conclusions on the subject. The poor and ill-fed were more liable to them than the rich, and more particularly that class of the idle poor who were addicted to habitual intemperance. In such, the stomach after a time was reduced to a state similar to that of a person who had been kept on food, either deficient in quantity, or of a quality insufficient to nourish the body. Under such circumstances, the stomach appeared to lose its digestive power, and a return to a nutritious diet often failed to restore it. He (Mr. Sedgwick) remarked, that when this had occurred, there seemed to be a proneness in the stomach to local inflammation and ulceration, analogous to what was known to take place in the lower animals who had been starved to death. In most of the cases the author had examined of perforation of the stomach, and, he might add, in all those where he had specially looked for it, he had noticed that peculiar condition of the mucous membrane termed mammillation, to which much attention has been directed of late years. With reference to its pathological importance, or whether it was in all cases to be looked upon as a morbid condition of the mucous membrane, he (Mr. Sedwick) was not prepared to offer a decided opinion; but from the frequency with which it had been met with in persons who had died suddenly from accident, as well as from disease, he was not disposed to attach much importance to it, beyond being an evidence of the suddenness of the death. After describing at some length the history and *post mortem* appearances of the five cases of perforation alluded to, he (Mr. Sedgwick) begged to submit to the Society the following points for consideration: first, the sex and age most liable to the disease; second, its diagnosis; third, its seat; and lastly, its terminations by perforation. It was generally stated that perforating ulcers of the stomach were most common in young, unmarried females, especially those belonging to the class of domestic servants. The author remarked that it was only in this country, however, that the greater frequency of the disease, at an early age, had been observed. The French pathologists seemed to consider it as more common later in life; whilst amongst the Germans, Rokitansky, who was celebrated for the great number of his *post mortem* examinations, had found it more frequent after fifty than under thirty. He (Mr. Sedgwick), in calling attention to the ages of the five cases under notice—one a female, aged thirty-eight, and the others men of the respective ages of fifty-three, fifty-nine, sixty-six, and eighty-two—observed, that the last case was interesting, as being the oldest on record, and was useful as showing that the disease might occur at even the most advanced period of life. The author stated as the result of his observations on diseases of the stomach, extending over a period of twelve years, that cases of perforation occurring late in life often escaped notice as such, whilst many more occurred without being published, and that consequently he was of opinion that this alleged greater frequency of the disease with us at an early age was more apparent than real. He thought the diagnosis of the disease, before perforation had occurred, might sometimes be very doubtful; and instanced the case of an old Chelsea pensioner, who had suffered from pain after food for upwards of thirty years, but had never had vomiting, or apparently any other symptom referring to the stomach. After death, which was the result of perforation, great thickening and induration were found around the ulcer, showing that it must have existed for several years. Mr. Sedgwick observed, that when perforation took place, he had always found the symptoms sufficiently indicative. These were, sudden and intense pain in the epigastric region, with not unfrequently a feeling on the part of the patient that something had given way in his inside, followed by collapse, and in some cases even syncope; tenderness over the abdomen, with occasionally tympanitis; a disposition to vomit, generally without the ability to do so; urgent thirst, and the suppression of urine. Some writers on the subject were of opinion that vomiting occurred in most cases of perforation; but in his experience of the disease the recurrence of vomiting was unusual, and he had only noticed it in one case, which was in other respects also an exceptional one. The suppression of urine, which did not appear to have attracted much notice, was as marked a symptom in these cases as in cholera, and the patient, notwithstanding the quantity of fluid so often improperly allowed to be swallowed, either did not pass any urine after the accident, or only a few ounces, which were turbid and high-coloured, and after death no urine was found in the bladder, which, as in cholera, appeared to be always firmly contracted. Whilst he considered that, with a due regard to these symptoms, so grave an accident as perforation of the stomach was not likely to take place without being recognized during life, he would beg to call the attention of the Society to the possibility of the opposite mistake occurring from cases simulating more or less perforation of the stomach, and where, after death, the stomach had been found free from disease. During the last year he had been present, by invitation, at two *post mortem* examinations where this was the case. As they both presented many symptoms in common, and the sudden death was due to the same cause in each, he would only describe the first—a woman, aged forty-three, and suffering from cancer of the womb. There had been, as was so often observed in these cases, great irritability of the stomach, with much nausea and occasional vomiting after taking food. For four or five days before death she had suffered much from pain in the pit of the stomach, and complained of tenderness on pressure there, for which turpentine fomentations had been used. The pain and tenderness increased, and after passing a night of great suffering, she was suddenly seized, at nine A.M., with agonizing pain in the epigastrium, and complained that the pressure of the bed-clothes over the abdomen distressed her. She quickly passed into a state of collapse, and died soon after eleven A.M. the same morning. The sudden death was found to be due to disease of the heart, which was in a very advanced stage of fatty degeneration; there was no evidence of peritonitis, and the stomach, beyond some patches of well-marked mammillation, appeared free from disease. After discussing at some length the seat of the disease, and referring to one of the preparations on the table as an exceptional instance of a perforating ulcer, occurring, not only in the cardiac division, but also on its posterior surface, he (Mr. Sedgwick) concluded with some remarks on the terminations of the disease by perforation. He observed that all the preparations on the table illustrated this tendency in ulcer of the stomach to go on to a fatal termination, either by communicating with the cavity of the abdomen, and so causing death by peritonitis, or by opening into an arterial branch, and so leading to death by hæmorrhage. Four of the cases related proved fatal by peritonitis from perforation, and, as usual, in each of them one ulcer only existed in the stomach. One of these cases was remarkable from the fact of hæmorrhage, to an almost fatal extent, having occurred five years previous to death, and on no subsequent occasion. In the last case, that of a labourer, aged sixty-six, the immediate cause of death was doubtful. In this case, two ulcers were found in the stomach, in both of which the perforating process had evidently been going on up to the time of death in the posterior ulcer leading to the hæmorrhage, which commenced three days before death, and was alone sufficiently profuse to account for it; whilst in the anterior ulcer there was a small opening communicating with the cavity of the abdomen, and which had given rise to peritonitis, which was, however, unusually slight. After commenting upon all the particulars of this interesting case, he (Mr. Sedgwick) was inclined to believe that the perforation in the anterior ulcer was the result of the over-distention of the stomach with blood, and that the hæmorrhage should be considered to have accelerated, rather than have caused, the death of the patient.—*The Lancet.*

Hemiplegia from Fibrinous Concretion, the Result of Endocarditis. Under the care of Dr. Farre and Dr. Kirkes.—We have observed, with some interest, two cases, during the past month, in the medical wards of this hospital, to the casual visitor not apparently connected, yet —if we are to trust the views of such a careful writer as Dr. Kirkes—both related most intimately in their pathological origin and nature. In one case, the patient has no pulse whatever in either radial artery; in the other, the patient has had loss of voice and hemiplegia, consequent on rheumatic endocarditis. The source of the disease, in both instances, being—according to Dr. Farre—the blocking up of arteries by fibrinous concretions. When we remember the anatomical character of the endocardial membrane, that it is similar to that of the membrane lining the bloodvessels themselves—namely, a layer of epithelium, with fibrous tissue; and, moreover, when we call to mind the various concretions one meets in the interior of the heart, in the dead-house, in those dying of acute inflammation of the membrane lining that cavity—concretions from the fatal coagulation of the blood during life, in the cavities of the heart itself—described more particularly by Bouillaud—down to the pin's-head little vegetations, so familiar to the eye, on the valves, it is not difficult to understand the rationale of Dr. Kirke's discovery; nor can we not see the possibility of even what Rokitansky further describes—a further form of concretion, or vegetation, on the valves, which he not unaptly styles the mulberry, or "cock-comb" fibrination, affecting the free margin of the valves, the tendons of the strings of the valves, which are probably thrown off from the latter into the circulatory current by the action of the heart itself. The mechanism of the causes of the disease is, indeed, rather too plain; but it must be known to the reader, that Dr. Todd and others who have had much experience of paralytic cases, seem to doubt the explanation given by Dr. Kirkes. Talking the matter over, however, with both physicians, it seems to us at present a question somewhat in the balance and unsettled. Twenty-one cases have been given by Dr. Kirkes, in which these deposits were found; and in nineteen he discovered disease of the valves, with endocarditis; in fourteen the fibrinous growths were found on the surface of the valves of the left side, or deposited from the scarlet arterial blood of that ventricle, as one might have, *à priori*, anticipated.

The chief objection which first, and very obviously, suggests itself is, if such fibrinous grains are given off from the valves of the heart (and we do not usually find Nature working so clumsily, it must be confessed), why is not paralysis a more frequent attendant on endocarditis and rheumatism? There is no doubt that Dr. Kirkes has found these fibrinous deposits, as previously described by Rokitansky; but from the analogy or identy of the lining membrane of the arteries to that of the ventricles, it may be yet open to doubt whether such coagula, found in distant arteries, may not be referred to an altered nutrition of the walls of the vessel itself: in other words, arteritis connected quite as much with the rheumatic diathesis, and altered state of the blood,—if Dr. Kirkes' theory be correct,—and that one of the middle cerebral arteries be the spot chiefly selected for such doposit. This case, kindly noted for us by Mr. Pugh (Dr. Farre's clinical assistant), is one quite clearly understood:—

Emma W——, aged twenty-six, apparently a healthy-looking young woman, admitted February 22nd. She states, that nine years ago she had severe rheumatic fever, for which she was leeched and blistered at the London Hospital; and had, she was then told, severe heart disease. When convalescent she was attacked with jaundice, and was confined eight weeks longer. Since then, however, till about twelve months ago, she remained perfectly well. At that period, a pain came on in the heart, aggravated by cold. She has had this pain again this winter, most severely: it attacked her quite suddenly, on the 19th of February, while she was at a friend's house; it seized her between the shoulders. She had, at the same time also, loss of power in the right arm, with loss of speech for some time; the latter, however, she gradually regained; but the pain still continuing severe in the chest, she sought admission into this hospital. She was first ordered eight leeches to the seat of the pain, and the ordinary fever mixture of acetate of ammonia, camphor, and nitre. She lies on her back; her breathing is short and quick; she cannot lie on her left side without a dragging pain; her countenance is anxious; she is flushed; sleepless at night; pulse eighty-six, jerking, and weak. She has little or no power in right arm and leg. With the stethoscope one detects a loud valvular, rasping, endocardial sound—particularly so over the right mamma, feeble towards apex.

February 24th.—She is much the same; still complains of want of sleep, and the pain in the chest. She is to have six more leeches; milk diet; to go on with her mixture; and a mild opiate at bed-time.

26th.—Not so well; still sleepless; pulse eighty-eight, small, soft, and weak; feels thirsty; pain in the chest still very severe; stethoscopic signs unchanged; right arm is warmer, and is gaining its power. She is evidently improving.

28th.—Still better; hemiplegia gradually going away.—*Lancet, March* 3.

Nature and Treatment of Diabetes Mellitus. By F. W. Headland, B.A., M.B.—Dr. Headland's object was not to examine the predisposing nor the exciting causes of diabetes, but to endeavour to determine the immediate operating cause. Three explanations have been given of the excessive formation and elimination of sugar.

1. *Theory of Renal Disease*, which has been supported by Mason Good and others. Some have said that the kidney is hypertrophied in diabetes; this, however, is not more than we might expect. Congestion has been alleged to be present; but this would induce dysuria. Albuminuria no doubt sometimes accompanies diabetes; but Dr. Headland did not agree with Schonbein that it is always a preceding symptom. Fatty disease of the kidney has also been alleged as a cause; but it is not more than a concomitant. The chief objection to the theory that diabetes depends on renal disease, is that sugar is found in the blood before reaching the kidneys.

2. *Theory of Saccharine Assimilation.* Under this title were arranged the doctrines of Bouchardat, Prout, Macgregor, Gibb, &c., who regard sugar as the result of deranged digestion. The advocates of this doctrine differ on material points. Prout and his followers, finding sugar in the stomach of diabetic patients soon after taking food, supposed the sugar to be formed in the stomach. But it is more probable that the sugar is excreted from the blood with the gastric juice, as with other secretions. Some pathologists attribute the disease to a morbid state of the liver, as Drs. Hughes Bennett, and Gibb. The objections to the theory of saccharine assimilation are, that the formation of grape sugar in the body has been shown to be a natural process; and that its excretion is not accounted for by this theory.

3. *Theory of Saccharine Non-Assimilation.* This title expressed the views held by the author, who regarded the formation of sugar or glucose as natural, but its excretion by the kidneys as not natural. Food is both nutritious and calefacient. The chief calefacient ingredient is starch. This is insoluble, and must be changed into dextrine—a change which can be effected by the ptyaline of the saliva and the gastric juice. In health, the dextrine is transformed into sugar; and it is rendered probable by the investigations of Dumas, Frémy, &c., that the sugar undergoes a further change into lactic acid, before it can be converted into carbonic acid. These changes are probably produced under the influence of ferments. There thus seem to be five links in the chain of transformation: 1. Starch; 2. Dextrine; 3. Glucose; 4. Lactic Acid; 5. Carbonic Acid. In some diseased states, the ferment required to effect any one of these changes may be wanting. The starch may not be changed into dextrine; in which case simple inanition results. If the transformation of dextrine is arrested, this substance will be excreted in the urine, and *diabetes insipidus* will be produced. If the process is arrested with the formation of glucose, this substance accumulates, and becomes a poison; it is therefore excreted, and carries with it much water for its solution. All the starch in the food is thus wasted; and, even where there is a deficiency of starch, the albuminous principles are converted into sugar. The calorific process is arrested; and the tissues of the body are consumed as fuel. It has not been determined what may be the influence which arrests the further transformation of glucose. The experiments of Reynoso and Bernard point to arrest of the respiration as a principal cause.

The *treatment* was arranged by Dr. Headland in three classes—erroneous, doubtful, and correct. Among the erroneous plans were first classed all medicines given with the view of preventing the formation of glucose. Some medicines, given with this view, have doubtless produced benefit in another way; as alkalies, iron, quinine, &c. The attempt to diminish the excretion by the kidneys is also mischievous; and the attempt to cut off the supply of water can be defended neither on theoretical nor on practical grounds. It is difficult to imagine how we can increase the disease by gratifying the patient's thirst: and the kidneys *will* excrete water, even though the supply of drink be withheld. Besides, the retention of an excrementitious matter is dangerous to life. Among the remedies of *doubtful* utility, the author classed diuretics, nervous excitants (as strychnia, &c.), treatment directed to the liver, and the use of oxidising agents. The indications of a correct method were defined as being both dietetic and therapeutic. The dietetic indication was to supply such articles of food as shall not necessarily pass through the stage of starch. Ordinary bread, potatoes, and all starchy food, must be proscribed. Gluten bread or brown bread may be used; and cabbages and other green vegetables in moderation. The allowance of meat should be increased, and should principally consist of *fat*. The drink should consist of dry wines—Claret or Bordeaux; and slightly sour milk may be also drank in large quantities. The latter beverage also appeared to Dr. Headland likely to meet the therapeutic indications which it has been endeavoured to fulfil by the use of rennet. It might also be given in enemata or in foot-baths. Alkalies may be useful; but more reliance is to be placed on diaphoretics, especially the former. The general health must also be improved by cod-liver oil, or such other remedies as may be indicated by the condition of the patient.

Intense Pain in the Foot, lasting several Years, cured by Removal of an osseous Growth from the interior of the Popliteal Nerve. By MR. QUAIN.—Elizabeth M——, aged 32, was admitted into University College Hospital, September 9th, 1845. She is married, has had two children, the second in July of the present year; she is of fair complexion and nervous temperament. A little time ago she was received as an out-patient on account of intense pain in the sole of her foot, at its fore-part, beneath and behind the toes. The first feeling of pain occurred about six years ago, when a little twitching was felt at the inner side of the foot. At that time the pain lasted a few minutes only at each seizure, but it soon used to last for an hour and upwards, and the duration has gradually increased till it came lately to be constant, not ceasing night or day. At first the patient could, by an effort of the will, divert her attention from the pain, and, when occupied, she used for awhile to forget it; but during the last four months she has been wholly unable to do so; indeed, she states that during those months she has not slept. She has not suckled either of her children, there never having been, according to her own statement, "an appearance of milk." A variety of treatment was resorted to before the patient applied to this hospital. She had taken many medicines during several years at home and from different hospitals, but of all of them she says that only one seemed to have any influence over the pain—that was arsenic. When that medicine was used for a time, the pain ceased during two or three weeks; then, however, it returned again as bad before, and the arsenic failed to have any beneficial effect. Having observed at the time that the woman was to all appearance in health, and that likewise she was an active-minded, energetic person, most anxious to get relief, and to do all that might be thought necessary to effect it, he (Mr. Quain) thought it likely that there should be a local cause—that is to say, an appreciable local cause—for the great suffering the woman had so long experienced, and he determined to examine the limb from the spine to the toes. In the appearance of the limb there was nothing noteworthy, and during the manipulation of the foot and the leg nothing unwonted was discovered; but while pressure was made upon the back part of the thigh, in the course of the large nerves, a tumour, not discernible upon the surface, was discovered. It was situated at two inches distance above the level of the upper end of the patella, and, being covered by one of the two hamstring muscles, was but indistinctly felt; still, when the muscles were relaxed, the outline was pretty well made out, but its consistence could not be determined, on account of the thick covering of muscle. Pressure over the tumour gave rise to the usual pain in the sole of the foot. Here, then, obviously was the real disease. It may be worth mentioning, that there was no more than a soreness in the seat of the tumour, and that only when it was pressed on. The patient now, for the first time, upon being questioned, mentioned that she felt a soreness when this part was accidentally struck, even before the pain arose in the foot; and she added, that about three years before her coming to the hospital, on pressing against the part, she felt a small lump. At that time, too, the pressure was, she recollected, accompanied with pain in the foot. He decided on laying bare the tumour, and, if possible, separating it from the nerve. It was with a view to the operation that the patient was admitted into the hospital.

Operation.—When one of the hamstring muscles had been turned aside, the tumour came into view. It seemed an enlargement of the nerve—the internal popliteal (posterior tibial), immediately after its separation from the great sciatic. The enlargement did not affect the nerve equally all around; it projected almost altogether on the deeper side. Upon the surface the nerve fibres were seen to pass uninterruptedly on; the tumour was therefore within. To reach it, the strands, or furnicula, were separated by division longitudinally of the connecting cellular structure, and when they had been turned aside freely, the subjacent mass was pushed out without any difficulty. None of the nerve fibres were injured. The tumour, which seemed a mass of bone, was grooved partially upon the surface from the fibres of the nerve; it was the size and shape of a good-sized walnut, weighed 228 grains, and when analyzed was found by Mr. Campbell to consist of phosphate and carbonate of lime, with a trace of sulphate of lime. It was not examined microscopically. On the day after the operation there was some local inflammation, accompanied with fever; but in a couple of days this subsided, and the patient left the hospital in a short time entirely relieved. There remained only a little numbness in the cicatrix when it was pressed on.

DUBLIN: PUBLISHED BY W. B. KELLY,
8, GRAFTON-STREET.

LONDON: S. HIGHLEY, 32, FLEET-STREET.

EDINBURGH: MACLACHLAN & STEWART.

March 15, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.

SENT FREE BY POST.

Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE Dublin Hospital Gazette.

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No. 5.—VOL. II. APRIL 1, 1855. PRICE 5D.

HOSPITALS OF THE DUBLIN WORKHOUSES.

Aneurism of the Thoracic Aorta, complicated with Phthisis.

BY DR. MAYNE,

PHYSICIAN TO THE HOSPITALS OF THE SOUTH DUBLIN UNION.

SOME of the greatest difficulties experienced in the diagnosis of chest diseases arise from the complications which occur in such cases. When there is only a single disease, it is in general easily recognized, but when there are two or more diseases, their symptoms are very apt to obscure or to neutralize each other, and then it may happen that two diseases, either of which would have been readily made out had they occurred in different individuals, offer a very difficult problem for solution, when developed conjointly in the same individual.

Under such circumstances, the physician must form his opinion from a due comparison of the physical signs with the constitutional symptoms, a careful consideration of the order in which the several symptoms have arisen, and a careful review of the patient's antecedents.

The following case exhibits a rare combination of chest diseases; it shows how tubercle of the lungs, supervening upon an aneurism of the thoracic aorta, may modify the aneurismal symptoms, and how thoracic aneurism and pulmonary tubercle, when they co-exist, may reciprocally obscure the diagnosis:—

William Mahon, a strong, athletic man, aged about thirty, by occupation a coal heaver, and, like most of his craft, of very intemperate habits, was engaged one day, in the month of July, 1853, in delivering coals out of a vessel at the quay, when he unfortunately lost his balance, fell through the hatchway into the hold below, a depth of from twenty to thirty feet, and was taken up insensible. After a few days' treatment in one of the city hospitals, his recovery was apparently complete; but on his return to work, he found himself unfit, and having struggled on for a short period, he was obliged, from sheer weakness, to relinquish his occupation. About this time he was suddenly seized with a violent convulsive fit, in consequence of which he was again subjected to energetic treatment; he was cupped, leeched, blistered, and mercurialized in the same hospital as before, and at length, after several weeks, he returned home.

Shortly after his second dismissal from hospital, a new order of symptoms arose: his breathing became short, so as to prevent him from walking quickly, or otherwise exerting himself; he was also troubled by a short cough, and under these circumstances, in the month of April, 1854, he sought for admission into the Workhouse Hospital.

At that time he had some symptoms of laryngeal disease, for his cough was husky and his breathing was stridulous; but as his voice was natural, and a careful exploration of the larynx led only to negative results, the organ of voice was inferred to have been healthy.

On exploring the chest, however, the upper part of the sternum emitted a dull sound on percussion; at this dull region the ear discovered a single systolic impulse decidedly stronger than that yielded by the apex of the heart, and also occasionally a single systolic *bruit*. It was singular that this *bruit* was sometimes present, and sometimes absent, at the dull portion of the sternum; but never, under any circumstances, could it be traced down to the apex of the heart; and sometimes, when the *bruit* was inaudible at first, it quickly became manifest on the slightest exertion upon the part of the patient.

There was also a very marked difference in the force of the currents in the vessels springing from the arch of the aorta: thus, in the right radial artery, the pulse was very weak; in the right carotid it was weak also; in the left radial the pulse was strong and full; whilst in the left carotid, again, it was extremely feeble.

Added to the above very characteristic symptoms, there was also a disparity in the intensity of the respiratory murmur in the two lungs: in the upper and anterior portion of the right it was feeble, throughout the remainder of the right lung and the entire of the left it was healthy; moreover, that portion of the right lung which yielded a feeble respiratory murmur was slightly, but yet perceptibly, dull on percussion.

There was no dysphagia, nor did the patient complain of any thoracic pain whatever.

This case was considered to have been an aneurism of the arch of the aorta, the diagnosis being founded upon—

1st. The supposed origin of the disease in an accident several months previously.

2nd. The habitually intemperate habits of the patient, which so often predispose to arterial disease.

3rd. The dulness of the upper part of the sternum, the strong impulse, and the occasional systolic *bruit* limited to the dull region.

4th. The pseudo-laryngeal symptoms.

5th. The disparity in the pulsations of the primary branches of the aorta.

6th. The disparity in the respiratory murmur in the upper and anterior portion of the right lung, as compared with other portions of both lungs.

Various remedies were tried with this man, without any material benefit, and he left the workhouse hospital evidently in the hope of a cure elsewhere. After several months' absence he was again admitted in October, 1854, and there was then a marked change both in his aspect and in his symptoms, so much so that some doubts were expressed as to the accuracy of the former diagnosis.

He had formerly suffered from a dry cough; it was now accompanied by a copious expectoration. His appearance was formerly that of a strong, robust man; he was now greatly emaciated and worn, and had marked symptoms of phthisical hectic, viz., occasional chills, night sweats, and diarrhœa.

The most singular part of his case, however, was that even the *physical signs had undergone considerable modification.* The upper part of the sternum was still, no doubt, dull on percussion, and the disparity in the pulsations of the radials, as well as the feebleness of the pulsations in both carotids continued; but the impulse, formerly so strongly communicated to the ear at the dull portion of the sternum, had notably diminished (for it now no longer exceeded that yielded by the apex of the heart), and the bruit, formerly heard there at intervals, was now positively gone.

There was this further remarkable change observed, that the respiratory murmur was now feeble in the antero-superior portions of *both* lungs, the feebleness of the respiratory murmur being accompanied by notable percussion dulness, *and these defects being now most observable in the left lung*, whereas, on former examinations, they were limited to a small portion of the right. The husky cough and the stridulous breathing still persisted, and bronchial rales prevailed extensively over both lungs, but without any stethoscopic evidence of the existence of phthisical cavities.

At length, as if to add to the obscurity of a case already sufficiently difficult, hæmoptysis set in, and lasted for several days. The quantity of blood expectorated daily was small: there was never any sudden gush of blood, such as usually accompanies the rupture of an aneurism, and he finally died exhausted.

The *post mortem* examination, which was made twelve hours after death, disclosed the following appearances:—

In the mediastinum there was an aneurismal tumour of the size and shape of a small orange. On either side the pleura invested it; in front it pressed against, but without eroding the sterum; and posteriorly, it rested upon and adhered firmly to the trachea at the bifurcation of that tube. This tumour sprung evidently from the transverse portion of the arch of the aorta with which it communicated by a large circular opening.

The arteria innominata at its origin was incorporated with the walls of the aneurism, and in its course upwards had evidently been compressed by the tumour, and hence the feeble pulsation of the right radial and the right carotid arteries. The left carotid arose fairly from the wall of the aneurism, and was consequently all but obliterated at its source. The left subclavian alone was free, taking its origin from the aorta to the left of the aneurism.

The cavity of the aneurism was occupied by recent coagula and some fluid blood, but it contained no laminated coagula whatever. On slitting up the trachea posteriorly, a very minute opening was found from that tube into the aneurism; it was only large enough to transmit a small sized probe, and through it, doubtless, the fatal hæmoptysis had occurred.

Both lungs contained crude tubercles in abundance; these bodies were found in greatest numbers in the upper lobes anteriorly, and in the left lung more extensively developed than in the right; but nowhere was there any tubercular excavation.

The bronchial mucous membrane was extremely congested, and the tubes contained a very abundant muco-purulent secretion.

The following may probably be assumed as the sequence in which the above diseases were developed:—

1st. A diseased condition of the arterial coats induced by intemperance.

2nd. Aortic aneurism resulting from the shock of the accident in a man predisposed to it.

3rd. Irritation of the air passages from the pressure exercised by the tumour upon the trachea.

4th. Tubercular disease in the lungs, determined by prolonged pulmonary irritation.

This case derives its chief interest from the changes presented by the stethoscopic signs in the latter stages. From it we learn that the impulse of an aneurismal tumour within the chest may be reduced surprisingly by the supervention of phthisis, probably in consequence of the enfeebled condition of the heart and the wasting hectic which so constantly accompany the progress of tubercle. It also reminds us that the feeble respiratory murmur in thoracic aneurisms may arise from causes unconnected with any pressure exercised on either bronchus; that an occasional *bruit* may accompany an aneurismal tumour within the chest, and disappear finally upon the occurrence of phthisis; and that in cases where pulmonary tubercle is really present, there may be hæmoptysis from causes independent of phthisis.

Finally, it adds another to the numerous cases already recorded, in which thoracic aneurisms simulate laryngeal disease, and shows that, contrary to the established rule, tubercle may occasionally progress *most* rapidly in the lung last affected.

RICHMOND SURGICAL HOSPITAL.

Case of Stricture of the Urethra in the Child, with Remarks.

BY CHRISTOPHER FLEMING, M.D., M.R.I.A.,

SURGEON TO THE HOSPITAL.

Patrick Conroy, aged seven years, applied as a Dispensary patient, at the Netterville Institution, in October, 1852. His mother stated that for two years he had experienced more or less of uneasiness in passing water, that micturition was unnaturally frequent, and that at the end of the act, especially, he appeared to suffer most acutely; that the penis was often, at those periods, tense and turgid, and that he was constantly pulling the prepuce; that she had never observed any blood in his urine, nor any other unusual appearance; that on no occasion was there any sudden interruption in its stream, that he had neither tenesmus nor prolapsus ani, but that he was always fearful of passing water, his agony was so intense; that she had applied for surgical relief, and that instruments had been used on those occasions; that the symptoms were, notwithstanding, persistent, and that they were now becoming more constant and more troublesome. The boy was fairly grown, and was in the average condition of boys at his age, in his class of life. He had yet a very pallid look, and a remarkably timid countenance, both of which might be fairly referred to his prolonged suffering and necessarily retired habits. On examining the region of the bladder and the generative organs, I could detect nothing wrong. The penis did not appear to be above the normal size for his age. The bladder contained evidently not much urine. The abdomen was soft and flaccid. The boy had no cutaneous or glandular disease. I considered it advisable to examine the bladder, and putting him under the influence of chloroform for this purpose, with the assistance of Mr. Torney, the Resident Medical Officer of the Institution, I proceeded to introduce a sound of the usual size for a child, when I found an obstruction in the region of the bulb. I changed the instrument, and ultimately succeeded in introducing a silver catheter below No. 1 on the scale in use here. I thought I felt a grating of the instrument against a calculus, but the sensation was unsatisfactory.

I transferred the child to hospital next day, and, after a short interval, under suitable treatment, I again examined the bladder. Some slight impediment existed in the locality above noted, but the silver catheter and sound now entered with comparative ease. I could not detect any calculus, neither could Dr. Hutton, who also, on more occasions than one, sounded the child with me. The contraction in the urethra yielded to the occasional introduction of instruments, and there was a decided improvement in the painful symptoms; but yet the irritability of the bladder continued, and it was remarkable that it was more so in the day than at night.

The boy never, whilst under my observation, had incontinence or retention of urine. On several occasions I examined the urine, and without other than an occasional increase in its density, found the following the average note of its condition:—

Colour, light straw;
Reaction, acid;
Density, 1010.12.

When allowed to remain at rest, a somewhat semi-transparent cloud, enveloping rather more than a normal amount of viscid mucus, subsided. No other stratum, linear or otherwise, was discernible. Under the microscope there were visible in this deposit some amorphous semi-crystalline masses of lithic acid, devoid of any special form, interspersed with epithelial scales and cells in irregular broken masses, and very few regular or perfect. Amongst those portions of epithelium which were considerable, I could not detect unequivocal evidences of crystals of oxalate of lime, but did some few of pus, and organic globules. There was no trace of albumen.

Generally once or twice in the week a silver catheter was introduced into the bladder, and ultimately at longer intervals, when No. 5, 6 passed with ease.

I find in the latter end of January the following note:—

The mother states that the symptoms observed in the passing of the urine have almost completely subsided—that there is no forcing or straining, and that there is no unusual excitability about the penis. At this period he was again sounded most carefully,' and no stone could be detected. The general treatment adopted consisted principally of the use of tepid baths at bed time, the exhibition of alkalies alternating with nitric acid and hyoscyamus, and those combined with uva ursa, or buchu, in doses proportioned to the age of the child. He was removed from hospital in February, 1853, with health good, and with manifest improvement in all the painful symptoms noted at his admission, the calibre of the urethra being then perfect.

Remarks.—" Diseases of the urinary organs, of such common occurrence in the more advanced periods of life, are occasionally met with in children, modified to an extent to entitle them to separate consideration. Difficulties often attend these investigations, and the symptoms which characterize their presence not unfrequently escape notice, as well from the carelessness of the ordinary attendants as from oversight of the practitioner. Yet they are a painful, a serious, and a distressing class of affections, and neglect in diagnosis, at their earlier formation, may lead to protracted misery, and often to incurable disease, if life, in the interim, be not compromised."*

The foregoing observations have been published some time back, and they are not inapplicable to the above case, it being one not free from complexity. Mechanical obstruction to the passage of the urine through the urethra of the male child is met with at different periods of infantile life, and is usually attributable to the impaction of a calculus in some one portion of the canal, obstruction from stricture being comparatively extremely rare indeed, unless it has been the result of the above cause, or has been attributable to some external injury. Hence the interest attached to this case, and hence the great importance of an accurate investigation of the attendant symptoms, before any unerring diagnosis can be arrived at. On a superficial review of those symptoms, the idea of vesical calculus cannot but have occurred to the mind of the least attentive practitioner, and yet, if those symptoms are closely analysed, the absence of some, usually pathognomonic of such affection, must be admitted. Thus there has been no abrupt interruption to the current of the urine at any time; there has been no incontinence or no retention to attract attention; there has not been hæmaturia. Such symptoms, though not indispensable to the presence of calculus in the bladder of the child or in the adult, yet, when absent, arouse suspicions as to the nature of the case. Those symptoms, in the present instance, were distinctly referrible to the stricture which existed, and were aggravated, and more than probably rendered more obstinate by want of early and suitable treatment.

Irritable bladder once superinduced in the child, and from anatomical reflexions so easily superinduced, is extremely slow in disappearing. A condition of inflammation of the mucous membrane is established, which it is as difficult to combat as is conjunctival or similar inflammation in children of a strumous habit; so that it should be always the object of the surgeon to check it as soon as possible, by subduing its cause. Was stricture in this case spontaneous, or was it not rather traumatic? and was not the irritability of the bladder in the first instance referrible to a morbid condition of the urine? I am much inclined to such opinion. Irritable bladder in the child is frequently identified with such state of urine. The surgeon is often too much disposed to attribute any vesical irritation in the child to the presence of stone, and with that view he proceeds to examine the bladder. Rarely, very rarely, is he provided with a catheter or a metallic sound suitable to that early period of life, and equally rarely is he enabled to direct a gum-elastic catheter safely. If not of proper calibre, he fails in the adaptation of a proper curve, and removing the stilette from such failure, he, in many instances, enters the bladder by chance, and not without injury to the urethra, as evinced by the appearance of blood, and the tortuous state of the instrument.*

From the history of the above case the bladder was not, in the first instance, reached after many efforts, and it is questionable whether such had been the case at all at that period. Catheterism in the child is by no means so very simple an operation, in the absence of any abnormal deviation in the course or condition of the urethra, and it is very intelligible, if the slightest obstruction be present, that such difficulty must be increased. Perhaps if the recorded case of spontaneous strictures in the child were more closely scrutinized, and if their history were more narrowly investigated it would be found that they were in reality the result of violence done to the urethra either by the presence of a calculus, so very small as ultimately to escape detection, and which yet had injured the urethra in its transit, or by the hand of the surgeon in endeavouring to relieve the supervening symptoms. I have witnessed two cases where I do think that the first was fairly the assignable cause, of extreme difficulty in the introduction of a catheter to relieve retention of urine in boys, the one aged about four years, the other three. In each all the ostensible marks of extravasation of urine existed which manifest themselves from lacerated or ruptured urethra in the adult. The penis—the scrotum were enormously distended with fluid, and the colour of rather a pinkish than darker hue; the perinæum was full; the bladder was distended with urine; no variety of instrument could be carried through the urethra, when in one of those cases it was found indispensable to open the urethra from the perinæum to relieve the child. No gangrenous inflammation supervened; all swelling subsided; the urine escaped freely through the artificial wound; and perfect cure was effected, without, as far as I could learn, the necessity of the introduction of any instrument subsequently.

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* Notes on the Urinary Diseases and Morbid Conditions of the Urine in Children. By Christopher Fleming, M.D., M.R.I.A., Surgeon to the Richmond Hospital, &c. Dublin Quarterly Journal of Medical Science, vol. xv.

* At page 840 of the first volume of this Gazette, I have ventured to suggest a curve of instrument which appears to be the fittest for the child. I seldom fail with such, and an instrument so formed will pass with ease into the bladder, when others have not succeeded.

In the second, incontinence of urine supervened, and all symptoms of retention and extravasation of urine gradually disappeared, the urethra being afterwards fully permeable. In the case above noted, I apprehend that the more appropriate treatment, in the first instance, in those of a similar character, would have been to improve the urinary excretion by those therapeutic means familiar to all surgeons; and if ultimately any examination of the bladder should be required, to proceed to such with the greatest gentleness and caution.*

On the admission of the boy (Conroy) into hospital, the treatment specified was fully justifiable, as a means to accomplish the cure of stricture, and as a precautionary measure against the possible presence of stone. That kidney or bladder disease in the child, as in man, may simulate, in all its symptoms, those of stone, is too well known to require comment here; and that in strumous children, especially, a peculiar form of tuberculosis may seize it, producing such symptoms, must be admitted. I acknowledge that my opinion respecting Conroy was opposed to the presence of any stone in the bladder, and that the ultimate establishment of strumous disease of the mucous membrane was my apprehension. In the communication above referred to, this subject has been noticed, and subsequent opportunities tend to confirm me in the opinions there advanced.

I beg to refer to them. After the lapse of two years this boy applied at this hospital, and is now under the care of my colleague, Dr. Hutton. His appearance and aspect are not materially altered. The urethra is not perfect, and, as far as I have as yet ascertained, his urinary symptoms exist, though, perhaps, in a less aggravated form. He has been, since admission, sounded for stone, and no stone as yet discovered. I find, since he left my charge, that he has not had any surgical treatment—a circumstance, I should say, indicating a material improvement in his symptoms, though the tolerance of suffering is remarkable in many of the subjects of urinary affections, both young and old, when not relieved on their earlier application.

WHITWORTH AND HARDWICKE HOSPITALS.

Case of Abscess of the Liver opening into the Gastro-duodenalis Artery, and also into the Peritoneal Cavity and Duodenum.

BY DR. M'DOWEL,

PHYSICIAN TO THE HOSPITAL.

It is well known to practical physicians that there are various ways by which nature gets rid of the contents of an hepatic abscess.

1st. The abscess may burst externally; in some cases this has occurred so high up between the ribs, as to resemble closely an "empyema of necessity;" in others, on the contrary, so near the umbilicus, and consequently so remote from the hypochondrium, as to remove almost all suspicion of its hepatic origin.

2nd. It may pass through the diaphragm, and open into the pleura; or into the lung, so as to be evacuated through the bronchial tubes.

3rd. The pus may escape into the cavity of the peritoneum—a rare occurrence; or,

4th. Into some portion of the intestinal canal—the stomach, duodenum, or colon, most frequently.

5th. The abscess may open into the gall-bladder, and the matter escape through the biliary ducts into the duodenum.

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* I cannot understand any case in which (unless from congenital malformation) the bladder of the child should not be reached by the natural route, if a suitable instrument is had recourse to; and I cannot but attribute to this the necessity for tapping the bladder, as has lately occurred on more than one occasion in a London hospital.

6th. The abscess may open into the vena cava; or,

7th. Into the pericardium.

8th. In a last group may be included those cases in which the abscess makes its way in two different directions: thus, it may open externally through the parietes, and at the same time into one of the hollow viscera.

In a remarkable case described by Dr. Graves, an hepatic abscess communicated with the stomach by three openings, and with the pericardium by a fourth.

The following case belongs to the last group, and furnishes an example of an hepatic abscess opening—1. into the peritoneum; 2. into the duodenum; 3. into the gastro-duodenalis artery.

Case.—The patient (Richard Stanley, 53 years of age) was a man of intemperate and dissolute habits, who, for many years, had suffered from a tight stricture of the urethra.

I first saw him on account of a violent and sudden attack of hematemesis. He had lost, literally, an immense quantity of blood, part of which was red and florid, the rest being black and coagulated. He was thoroughly blanched, cold, and almost lifeless. There was, at this time, a circumscribed hard tumour in the epigastrium, of a rounded form, and tender to the touch, which pulsated strongly, and over which a loud systolic *bruit de soufflet* existed.

The man was apparently in a dying state; however, under the use of stimulants, &c., he rallied, the hæmorrhage from the stomach ceased, but much dark melænic matter was passed from the bowels. The next evening a quantity of pus (about a pint) was discharged *per anum*, and for several days pus in smaller quantities continued to be passed.

After this the patient regained somewhat his strength, and for a month enjoyed tolerably good health, when he was again suddenly seized with hematemésis, and lost a very large quantity of blood in a few minutes. But, although the hæmorrhage did not recur, the consequent prostration and debility were so extreme that for a a day or two his friends almost hourly expected his death. Nevertheless, he gradually rallied, and two days after the attack of hæmorrhage passed, as before, a large quantity of pus by stool. He now became a patient of mine in the Whitworth Hospital, and was under observation for twenty-two days.

During this period he occasionally passed purulent matter of a healthy character, but did not again lose any blood from the mucous surface. The waxy, pale hue of his countenance, however, plainly denoted how serious had been the loss of vital fluid in the two attacks of hæmorrhage already described.

The tumour in the epigastrium, which the patient now stated had existed for several months, presented the same characters as before, but could now be traced under the ribs on the right side to become merged in a general enlargement of the liver.

It soon became evident that in this case the system was incapable of rallying; the prostration continued to be extreme; the feet and legs became anasarcous, troublesome diarrhœa set in, the scrotum became gangrenous, and death finally ensued from exhaustion, two months after the first attack of hematemesis.

Post Mortem Examination of the Body.—The abdomen contained a good deal of serum, and pus likewise flowed from the peritoneal cavity at its upper part. The liver was much enlarged. The first portion of the duodenum adhered to the lobulus quadratus, and, in this situation, a circular opening, an inch in diameter, communicated between the intestine and an abscess which had extensively excavated the corresponding portion of the liver. By a second and smaller perforation, the abscess had opened into the cavity of the peritoneum.

The head of the pancreas was thickened and enlarged. The gastro-duodenalis artery, in its course behind the first portion of the duodenum, had been opened into, but was now filled by a firm and lengthy coagulum.

The stomach and spleen were healthy. The kidneys had undergone degeneration; the left lung was tuberculous.

Remarks.—The occurrence of hematemesis in connexion with hepatic abscess is most unusual. I am not, indeed, aware of any case, except the one now detailed, in which it has been observed.

This symptom was calculated to render the diagnosis more difficult, by directing attention to the stomach rather than to the organ primarily affected.

We observe also, that we have here an instance of blood of a florid colour, constituting the fluid ejected from the stomach by vomiting. This is to be explained not only by the direct arterial source of the hæmorrhage, but also, probably, by the fact of a larger quantity of blood being poured into the stomach from the duodenum, than its acids were capable of altering in colour. It is also deserving of notice how much the external tumour possessed of the characters of an abdominal aneurism—as for example, in its strictly median position, and in its possessing both impulse and *bruit de soufflet*. It is not a little remarkable that, although an artery of such magnitude as the gastro-duodenalis was opened, death was not directly owing to hæmorrhage. Twice the reparative powers of the system closed up the opened artery, and the last time so effectually, that a firm lengthy clot, similar to that which results from the application of a ligature, was found to have sealed up the vessel to some distance on either side of the ulcerated opening.

The communication between the abscess and the duodenum would appear to have been somewhat valvular, as the discharges of pus were occasional and intermittent.

The opening into the peritoneum must have occurred very shortly before death, as there were no traces of recent inflammation in the peritoneum.

BELFAST GENERAL HOSPITAL.

Masked Typhus Fever mistaken for Apoplexy.

[Communicated to the Belfast Chemical and Pathological Society, February 24, 1848.]

BY P. M. LYNCH, M.D.,

ATTENDING PHYSICIAN TO THE HOSPITAL.

The following very interesting case of typhus fever presents some peculiar symptoms :—A farmer, aged fifty-nine, very tall and athletic, but not fat, had always enjoyed good health till about three weeks before his present illness, when he began to complain of wandering pains about his back and loins. He then began to droop in his health, and complain of general languor, "malaise," and incapacity to walk as usual without a sense of fatigue; and for three days before his attack, some headache, with a sense of chilliness, but no marked rigor. His habits were occasionally rather intemperate. The present illness commenced rather suddenly while in bed, with a supposed seizure of apoplexy, about thirteen days before Dr. Lynch saw him. At the end of eight days, he had a second similar attack, after which he wandered and raved occasionally, but on being roused, he answered rationally. Dr. L. found him on his first visit (6th Feb.), occupying a very close and small apartment, lying prostrate on a feather bed and curtained. His breathing was heavy and cerebral, of variable frequency, at times very slow; pulse about 96 to 100, feeble; tongue soft at edges, but rough in centre; skin rather cool and soft, with cold extremities; no impulse of heart; hiccough, and occasionally catching at imaginary objects. Besides, he had a general bronchitic affection, with difficult expectoration of thick mucus, tinged with exuded blood. On the following day he became bathed in a general perspiration, and the skin assumed a leaden hue. There was a manifest tendency to coma, all the other symptoms were greatly aggravated, and the powers of life sinking into the moribund condition, with complete relaxation of the sphincters, and failure of the power of deglutition. From this alarming condition, he emerged within the next twenty-four hours; consciousness and speech returned; the crisis was manifested by copious perspiration and sleep, and in the course of the next few days, convalescence was fairly established, and he is now (24th February) quite well. The treatment, from the thirteenth day, consisted of a variety and abundance of stimuli, both externally and internally, with nourishing enemata of chicken-broth; wine and arrow root every three hours. It was remarked that, during convalescence, though the frosty air was freely and constantly admitted, the bronchial affection rapidly declined. Dr. L. considered the case an admirable example of the severer congestive typhus, in which, as described by Dr. Corrigan, "the function of circulation is almost suddenly struck down."

ON CANCER, AND A FORM OF THIS DISEASE WITH BENIGN CLINICAL FEATURES.

BY ROBERT D. LYONS, M.B., M.R.I.A., &c.

[Read before a Meeting of the Pathological Society, Wednesday Evening, February 28, 1855.]

Since I last had the honour of addressing this Society on the subject of Cancer, it has occupied a very large share of attention in the profession, especially in certain scientific circles on the Continent.

A work of great importance has appeared from the pen of a distinguished French surgeon of the highest reputation, and of very large experience, on the special subject of the Diseases of the Breast, and treating largely of Cancer.

The pathology of this malady has recently undergone discussion in the French Academy of Medicine, when some of the highest authorities of the day in clinical and practical medicine and surgery, and scientific pathology, expressed their views at considerable length.

In the German, Swiss, and some other schools also, cancer and the diseases which may be provisionally grouped under the general term Cancroid, have received a considerable degree of attention.

It is much to be regretted, however, that notwithstanding the amount of investigation which has been devoted to the subject, the state of science regarding it still appears to be most ill-defined and unsatisfactory.

Conflicting opinions prevail on all sides, and on the most fundamental points. There seems not to be any common ground on which to base a clear, comprehensive, consistent, and logical view of the pathology of Cancer. Definitions and descriptions are arbitrarily put forward on the one side, and as arbitrarily rejected on the other.

Theories are constructed on the most vague and illogical principles; one now very prevalent with the Germans is of such extensive and accommodating dimensions, as to obviate (for so, at least, it seems to me) the necessity for any exertion whatever of diagnostic powers. Thus, in accordance with this view, Cancer is placed at the head of a category so loosely defined, as to embrace, at one extreme, this disease in its most typical form, and at the other, any kind of hypertrophy of the epithelial elements of the skin or mucous membranes, for I cannot see that any ONE ESSENTIAL DIFFERENCE has been pointed out as a diagnostic between the simplest epithelial hypertrophy and the so-called Epithelial Cancers, or that it has been shown wherein the one differs from the other in any property not purely accidental.

Much injury has been done to this branch of pathological inquiry, and I cannot but believe that its progress has been much retarded by the great neglect on the part of many who have largely shared in labouring to advance it, of those close logical principles of reasoning, and that salutary cautiousness of induction, by which alone stable and unshakeable results can be arrived at, and which are regarded as absolutely indispensable for the successful prosecution of any inquiry in other departments of knowledge. And I will venture to state, in regard to medical subjects, that there has been more logical accuracy displayed in many a memoir on one fractured bone, or a single acoustic sign, than is to be found in several of the voluminous treatises on Cancer and the diseases confounded with it. Indeed were men to speak and write on the former subjects as they do on the latter, they would bring on themselves but justly-earned ridicule, if not contempt.

It is to be considered, however, that in approaching the investigation of cancer and its diagnosis, we come to deal with a subject of the highest difficulty, and a question of the greatest possible complexity. And it is because many do not appreciate this difficulty and complexity sufficiently, that they commence the inquiry with imperfect knowledge, if not total ignorance, of the nature of the results attainable, and the kind and degree of approximation to certainty which is possible to be acquired.

The reader of a popular treatise on astronomy finds the weight of the sun and moon, or the distance of the nearest fixed star, given with a summary precision most facile and satisfactory; it is only when he looks a little deeper into the science that he finds these are but approximates to the true figures, and depend on a chain of evidences, each link of which is itself but an approximate value.

Those satisfied with a superficial, and, so to speak, popular knowledge of pathological science, can neither understand nor appreciate the difficulties of such a problem as the diagnosis of cancer. How incompetent, therefore, must they be to undertake its investigation!

I must here observe, and that with censure, on a very prevalent source of error and perplexity, and, as I fully believe, a great impediment to successful research into the pathology of this disease; I allude to the loose, inaccurate, and slovenly language, if it do not deserve a worse epithet, so constantly employed to designate cancer and the diseases confounded with it. Indeed it is hardly possible to refrain from saying, that this loose language is often used as a subterfuge to veil ignorance or to cloak inaccuracies of diagnosis. I allude to the use of, or rather the abuse of, the terms, "benign," "malignant," "of malignant nature," "somewhat cancerous," "growths of a malignant character," &c., &c., and such like vague expressions, which it is impossible to say ever received any defined meaning or acceptance in pathological nomenclature, or are capable of conveying any clear or definite ideas. And yet these vague terms have been, and are still constantly brought into discussions of the greatest complexity in themselves, and in which, even with all the aids of scientific research, conducted with the requisite logical precision and accuracy, it is not always easy, and is sometimes not possible to arrive at clear results. The term "malignant," of all others especially, has been abused and misused; it is made at one moment the synonyme for cancer in the strict acceptation of this latter word: at another, we hear it applied to an ulcer of local, or a fever of general origin and character. Many diseases are unquestionably malignant, or may become so, which have no other feature in common than that they are capable of producing rapid destruction of parts, great suffering, or speedy death.

Vaguely used to classify diseases, the terms "benign" and "malignant" are of as much import as those of "tame" and "wild" would be in zoological classification, which has been already well observed by Lebert.

Strictly and properly speaking, these terms embrace only certain *clinical* features of disease, and in no way imply special pathological characteristics. A fever, a pneumonia, an ulcer may run through all its stages with most malignant characters; a cancer may be seen, as I trust to be able to show, free from pain, not destroying adjacent parts, and in all other respects benign in its clinical features to the end.

I have said, on a former occasion, that the diagnosis of cancer was a high, abstruse, and complicated problem, requiring for its solution varied and extensive collateral knowledge. Many have an idea that cancer is a fixed, stable, and concrete essential disease, with an invariable composition, and in its characters and properties always corresponding to an immutable type. Now nothing can possibly be more erroneous than such a view. If cancer be anything constant in pathology, which I am not clear that it will eventually prove to be,—and I should hold it no extravagance in scientific pathological speculation, even at present, to say it was not,—so far is it from being a fixed and stable essence, so far, in fact, to use a bold comparison, is cancer from being, in pathology, what an acid is in chemistry, possessed of a definite composition and constant corresponding powers, that it must rather be likened to an assemblage of factors, some of which are variable, many inconstant, some of which may be entirely absent, and most, if not all of which, may be eliminated or changed in succession, without injuring the integrity of the compound. It may be compared to an equation of many terms, few, if any of which, are constant, and most, if not all of which, may undergo substitution.

If we take in detail the various characteristics which have been assigned to cancer, we shall find that, of all, not more than one, if even one, for some will question èven this, can be assumed to be essential, constant, or necessary. There are things both harder and softer than cancer; it is not unfrequently painless; it has neither colour, form, nor consistence, singly or in combination, capable of unerring recognition, for I have seen them all signally fail as diagnostic criteria. It does not always ulcerate; it is not necessarily propagated to secondary seats. Non-cancerous diseases will relapse; chemical ingenuity has been in vain exhausted to discover the specific element of cancer; it has no reliable diagnostic character on section; its succus, when present, which is not always the case, especially in scirrhus, is not distinguishable from that of some other tumours. One characteristic remains, its histological structure. I have before fully expressed my views on this subject, and do not mean to discuss the question at present: but it is to be observed that others deny speciality of structure. M. Velpeau is amongst this latter class; and yet he talks of a special essential characteristic, to be yet discovered, and which he believes will reward the labours of future investigators: a sort of pathological *je ne sais quoi!*

Whether it be a clinical feature, a chemical element, or a special histological form, which he regards as the most likely to furnish this invaluable and infallible criterion, he has not taken on himself to indicate. It is to be observed that he nowhere in his work gives us any aid whereby we may be able to determine whether a disease be cancer or not, till the question is put beyond doubt. When universal infection, a malignant clinical course, and death decide the issue, it is hardly of use or interest to entertain the question of diagnosis.

It will be necessary here, in the interests of our subject, to consider somewhat in detail a few of the statements, in many respects most remarkable, put forward by this distinguished author.

M. Velpeau advances, and not without some reason, large claims to the grateful consideration of his professional brethren, and of humanity in general, for his labours in this department of medicine. Granting, however, his eminent services, we cannot agree entirely with several of his positions; and we do not believe that some of his too positive opinions will stand the test of experience. Indeed, if we be not greatly mistaken, they do not hold consistently with each other, and I believe they even involve contradictions. M. Velpeau, it is to be observed, is one of those who think that the unaided sight is sufficient to establish the nature of a given tumour; and yet, as already remarked, we look in vain through his work for any character, or even definite assemblage of characters, whereby we may be able positively to determine, in any particular instance, whether a specimen of disease placed before us be or be not cancer.

He believes in a special cancer, and yet he gives us no definite clinical, pathological, or anatomical characters, or particular grouping of some or all of them, whereby we may recognize what is and what is not cancer. The following passage will exhibit the uncertain and, as it appears to me, inconsistent nature of his views:—

"The preceding remarks," he says, "must not, however, cause me to be ranged amongst those who contemn the microscope. I accept, on the contrary, the new facts which this instrument has brought to light, facts of which I but contest the interpretations or the applications. I do not deny, amongst other things, that a notable difference, easy of recognition, exists between the so-called cancer cell and the cell of other kinds of tumours. I grant also that this kind of globule, that is to say the cancer globule, is absent in reality from the greater part of the benign tumours; experience having for a long time proved, on the other hand, that these tumours differ from cancer: I even find that the microscope confirms fully in this point of view the results of simple observation.

"Only," he continues, "I add, that even if reduced to these terms, the question must not be resolved but with reserve. Tumours, in which the microscopists have found neither cancer cell nor nuclei, are not the less true cancers for the surgeon. I have the conviction that the cancer element is a special element, and that if it be not found in certain tumours really cancerous, it is because it is not yet sufficiently well known. Perhaps also there may be many sorts of cancer globules."

Even with further limitations than those here assigned by M. Velpeau, it would not be difficult to show that the histological element, the cell found in cancer, is the only one character, of all those assigned to the complex idea of cancer, which will bear the test of a close process of investigation, and even if not universally present in cancers, it would be found that it is at least the most constant; and thus we should be forced either to accept it provisionally as the element *par excellence* of cancer, or to say that this disease, the unity and special persistent identity of which have been admitted for so many centuries, has no single constant character.

We will here notice only one of the general characters, that with which the idea of cancerous malignity is most uniformly associated in the minds of physicians and surgeons, that of relapse and infection of distant parts. And yet, what authors who have at all examined the subject, and can now be admitted as authority, agree on this one point? It was the distinctive character with Boyer. What is the view of it warranted by more recent inquiry? From the observations of Walsh, and Herrick, and Popp it appears that in about 27·6 per cent. of cases of cancer the disease continues to the end, in respect of its local manifestations, an isolated affection.

Velpeau claims to have cured twenty-two cases of genuine cancer, a statement which, of course, when taken positively, which, I may be allowed to remark, I for one am not disposed to do with regard to it, precludes the possibility of relapse and infection.

M. Lebert believes cancer to be a disease which necessarily leads to a fatal termination by a peculiar inherent destructive quality, independent even of its disorganization of tissues with which it may come in contact. It will be seen, therefore, that on this point there is no uniformity of opinion, nor even an approximation to such; and the same may be said of any or all the other characters assigned to the disease, whether clinical, pathological, or anatomical, with one exception, as I, in common with many others, am disposed to believe. And I conceive that by the logic of least difficulties it would be possible to enforce on all who will give the subject sufficiently close consideration, the acceptance of the histological element as the essential one of cancer, at least provisionally, and in the absence of an absolutely and indisputably constant character. Whether any one answering these last requirements exists, and will ever be determined, is another matter, which I do not choose to enter on at present.

In the foregoing passages I think I have said enough to show that M. Velpeau has at least not followed out his admissions, and the pathological positions he assumes, to their legitimate and absolute conclusions. In another statement, not less important, his logic is equally defective, and it is the more necessary to notice the passage, as it is to the views of others that his observations apply. It runs thus:—"To establish that every tumour, formed of homœomorphus cells, must be ranged in the class of benign tumours, as well as that every tumour in which the heteromorphous cell exists is necessarily a cancer, they, the micrographs, have concluded too fast. To state that the cancer of the lip, the cancers of the face, of the anus, of the uterus, of the penis, that the cancer of the integuments in general are but hypertrophied follicules or a mass of epithelium; that the horny productions, the corns, &c., and these sorts of cancers, are of identical nature, will even *a priori* always appear strange to surgeons of experience." And doubtless it should and ought, had any such unwarrantable, illogical, and inconsistent statement been ever advanced. But here, in a manner to me most unaccountable, M. Velpeau has himself confounded things most different. The most eminent microscopic observers have strongly protested against the use of any such words as *benign* and *malignant;* and they have plainly admitted the frequent occurrence of homœomorphous tumours with a highly malignant clinical history.

Again, I am not aware that it has been anywhere said by well-informed histological pathologists, that the cancers of the lips, face, &c., are but collections of epithelium. M. Velpeau and others constantly, and indeed now professedly, confound epithelial growths with cancers, and designate them epithelial cancers. But microscopic observers have long recognized the existence of a true cancer of the skin, the lips, the face, the anus, and the uterus, and carefully separated it from the epithelial, fibro-plastic, and other affections of these parts.

Such want of precision of language, in dealing with an important scientific subject, as has been here exhibited by M. Velpeau, is ever most prejudicial to the interests of science, and it is much to be regretted that this distinguished surgeon should have been, by any cause, led to countenance, and indeed directly to make such a charge as the foregoing upon the histological investigators of cancer; but in fact it requires only a very limited acquaintance with the literature of pathological histology to know, that however its cultivators have erred on the side of making unnecessary distinctions, they have hardly laid themselves open to a charge of confounding lesions even slightly different from each other.

Those who have carefully followed the discussions of the subject of cancer, its diagnosis, and the question of its curability, which occupied many sittings of the Academy of Medicine during the past year, must have observed how much the difficulties of the inquiry were enhanced by the want of accordance in the interpretation of the terms employed on both sides, and the actual value assigned to them by each.

On the one hand, cancer was spoken of as a definite and positive pathological entity, easily enough recognizable; but no definite characteristics, clinical or otherwise, were laid down to show in what its being and essence consisted, or by which it may be positively known.

On the opposite side, a definite structure was assumed; and between these two views a third may be recognized, effecting a kind of compromise, and establishing a sort of middle term, or neutral ground. Thus it is that M. Barth speaks of a cancer with cells, and a cancer without cells.

Some observations of M. Malgaigne, occurring in the course of this discussion, merit attention. This distinguished surgeon may be regarded as the supporter of a kind of moderate antagonism to the views of special structure, and yet his remarks show well the great difficulties of diagnosis without reference to this criterion, and the absolute impossibility, in some cases, of any positive determination of the nature of a given structure without microscopic examination.

In speaking of the present and former conditions of the question of diagnosis in cancer, he says:—"The noted case of disease of the testicle, presented at the Société Anatomique in 1843, was pronounced encephaloid by M. Lebert, and tubercular by Deville."

"Thus," he says, in a paragraph which follows, "in 1844, there was not a surgeon, not a pathological anatomist, who knew how to recognize a tumour upon the table. And when such difficulties were experienced in diagnosing a tumour which one held in the hand, how can you pretend that it could be diagnosed in the living?"

"In the present day," he continues, "at a distance of scarcely ten years, is it still the same? Do you hear the same language as at the former epoch? No; the discussion of 1844 would be impossible at the present day. There is, permit me to say it, a distance of ten centuries between the ideas of then and of to-day. Both ideas and expressions, all are changed. We hear today but of cancers with cells, fibro-plastic tumours, epithelial tumours, cancroid growths, and hypertrophies of the mammæ. And what is it that has effected this change? It is the microscope. The microscope alone has completely changed the face of science on this point." Such are the words of Malgaigne, one who, as we have said, is yet no advocate for special histological elements.

(*To be continued.*)

PATHOLOGICAL SOCIETY MEETINGS.

March, 1855.

PROFESSOR LAW IN THE CHAIR.

DR. STOKES exhibited a specimen of purulent infiltration of the lung, which was of great interest as being illustrative of the prevailing epidemic. It was taken from the body of a man who died in the Meath Hospital of fever during the past week.

When the patient first came under notice the exact day of his fever could not be determined, but it appeared he had been more or less ill for a fortnight.

It was found very difficult to ascertain whether or not the spleen was enlarged, owing to the great rigidity of the muscular walls of the abdomen. The case went on for some time without any notable change, but was marked throughout by extreme prostration, although there was no loss of power in the action of the heart. It gradually appeared, however, that the posterior portions of the lung were becoming dull, but this dulness was never complete, and the stethoscope did not indicate impermeability of the pulmonary tissue. The patient now began to have frequent sweats, diarrhœa, and delirium, which formed the most prominent symptoms: and towards the close of the case, the dulness extended, but the crepitating râle never disappeared. The pulse likewise became very rapid, up to 140, but the heart's action continued vigorous. On the twentieth day a profuse eruption of petechial spots came out over the back. On dissection, it was found there was nothing remarkable in the intestinal canal, beyond a slight enlargement of volume in Peyer's glands; but this circumstance is of interest, not so much in itself, as because it shows that we have been, perhaps, too much in the habit of regarding what is termed follicular enteritis as an invariable concomitant of the diarrhœa of typhus fever. The enlargement of the spleen shows also the changeable character of the epidemic in this country. In former epidemics, as in the fever of 1817, the spleen has been found very much enlarged. In subsequent epidemics there was a cessation of this symptom; and again, in those cases known by physicians as the short relapsing typhus fever, the enlargement of the spleen became a prominent feature. Latterly we have not so often found it, yet here, however, was a case of this kind. The heart was free from disease, but the lungs, particularly the left, were in a state of sero-purulent infiltration, so that when a section was freely made a great quantity of sanious pus flowed out.

Dr. Stokes observed that these cases of purulent infiltration of the lung were examples of a morbid state clearly different from that of Laennec's third stage of pneumonia. Its antecedents, the mode of succession of its physical signs, and even its anatomical characters, pointed it out as one of that class of local diseases developed under the influence of a general pyogenic state. With respect to the order of succession of the physical signs, he remarked on the want of the signs of consolidation, which in ordinary pneumonia occur midway between those of the inflammatory congestion and those of purulent infiltration. In connexion with the fever of this country, there had been a strong epidemic tendency to this affection lately developed. In some cases, as in that which he now presented, the alteration had occurred during the existence of the fever, and while maculæ existed on the surface. In other cases the pyogenic tendency was not exhibited until after a short convalescence from the primary fever. Of this a remarkable case had lately occurred in the Meath hospital. The patient had gone through a severe typhus fever, and was held to be convalescent; in a very few days an œdematous swelling, attended with a slight blush on the surface, appeared along the line of the lower jaw. This was followed by another swelling in the right occipital region. The pulse became rapid; the breathing laboured; and the posterior portion of the left side showed comparative dulness on percussion, and a large muco-crepitating râle. Death soon took place. Depots of purulent matter were found in the neck, and the posterior mediastinum, and the left lung was found in a state of semisolidity, and infiltrated with a dirty yellowish pus. There was no red hepatization; nor did the incised surfaces exhibit the peculiar granular aspect of the third stage of pneumonia.

In a third case, at present in hospital, the patient, after having recovered from a very low typhus, was attacked with pain in the right elbow-joint, and within twenty-four hours the parts presented all the appearances so well described by the late Dr. E. M'Dowel in his paper on periostitis and synovitis, in which he dwells on the characters of this purulent disease as affecting the joints, and subsequently the internal organs.

Dislocation of the Navicular Bone.

Professor R. W. **Smith** exhibited a cast of a foot, representing a luxation upwards of the navicular bone. The patient, an adult male, met with the accident while riding: the horse fell with him, and lay across his foot, which remained entangled in the stirup. No effort was made to replace the bone, as the man did not apply for professional assistance until it was too late to reduce the displaced bone.

The features of the injury consisted in a projection, at the inner edge of the dorsum of the foot in front of the head of the astragalus; and a remarkable flattening of the plantar region: the sole of the foot had become perfectly flat. The accident occurred several years since, and the man now enjoys the unimpaired use of the limb. The partial displacement of the navicular and cuboid bones upwards has been described by Liston, but the preceding case furnishes the first recorded instance of the luxation of the navicular bone alone.

Case of Spontaneous Fracture of Clavicle and of Humerus identified with Cancerous Diathesis, in the Absence of Mammary or Uterine Disease.

Dr. Fleming exhibited a cast, morbid specimens, and drawings illustrative of a malignant lesion of bone familiar to many of the members of the Society; and yet, one not very often witnessed in its recent state. He alluded to cancer of bone.

In connexion with the special case, however, which he wished to bring under the notice of the Society, there was much interest not alone to the pathologist, but also to the physiologist and practical surgeon. The subject of the case was a widowed woman, aged beyond seventy; she was mother of many and healthy children, and up to the period of about three months before her death, had been in the enjoyment of good health, with the exception of some casual and irregular pains, which she described as rheumatism. She passed through life well, and was always actively employed in her ordinary domestic occupations. Dr. Fleming was required to see her in the early part of last November, in consequence of a large tumour occupying the lower third of the right arm, which tumour had gradually supervened on fracture of the humerus in that locality, about a month previous to his visit. She was then bed-ridden, in a miserable state of destitution, and labouring under that irritative fever so frequently identified with malignant disease. Dr. Fleming recommended her removal to hospital, and at the time she reached the hospital, some days subsequently, she was so apparently moribund that the porter was doubtful as to the propriety of her transfer to a ward. She however rallied, and lived for a month or so under inspection, being ultimately much emaciated, and dying rather of general prostration, than of any special organic disease.

The following history of her case Dr. Fleming condensed as much as possible, with the view to place before the Society only its more prominent features, as bearing on the specimen presented. About four or five months before her death, whilst removing some clothes from an ordinary drying line, she felt a crack in her left collar bone, as if the bone had snapped across; she experienced pain and uneasiness in it towards its sternal end, at the time, but neither one nor the other was of a nature to interfere with her ordinary domestic work. She did not apply to hospital or dispensary for advice; all uneasiness subsided gradually, and her different manipulations were carried on as before. She now accidentally perceived growing up, as she thought, from the fractured clavicle, a lump or swelling, which was painless, and gave her no trouble. Her account of this tumour, and another which manifested itself in the left popliteal space, about the same time, was really most unsatisfactory and most unconnected. In fact, the questions were begging questions as regards their history. It is certain, however, that neither the one nor the other gave her annoyance to require surgical aid. Now a fresh feature of interest manifested itself in her case: whilst in bed, and merely taking from her daughter a cap which she was handing her, her right arm fell helpless and deformed at her side, and that with a loud crack, which attracted the attention of those around.

She was brought to hospital: a fracture was found to occupy the lower third of the humerus, and it was properly adjusted. She returned home, and now, for the first time, pain and swelling supervened in the site of the fracture. She ultimately became helpless and bed-ridden, and under these circumstances Dr. F. first saw her, at the instance of the medical gentleman in charge, about six weeks from the period of the last fracture. The position and outline of the limb were much as represented in the cast. The forearm and hand were largely œdematous, and the integuments of the elbow equally so, with an erythematous blush over them; there was effusion into the elbow joint. The lower portion of the arm was tensely swollen, somewhat oval in shape; its circumference, at its widest part, measuring twenty-two inches or so, and tapering off to about ten at either end, whilst the girth, at the upper part of the limb, was little more than five. The swollen part of the arm presented a shining mahogany or mulberry colour, and communicated a most distinct sensation of fluctuation, leaving the impression that there was no other than an acute abscess in connexion with the fractured bone, the idea of a bag of traumatic ecchymosis being nullified by the comparatively late period at which the swelling supervened. That the bone was fractured, and that no attempt at union had been effected, was too manifest, as well from the peculiar twist which existed, and was represented in the cast, as from the facility with which the limb could be almost bent on itself in any direction. The superficial veins of the arm and forearm were full and tense; the radial and ulnar arteries were easily discernible at the wrist, and the temperature of the limb not above that of the opposite one. Such is the outline of this interesting case. No mammary cancer, no uterine cancer, no symptoms of either disease existed; no foundation for the existence of such was manifest. Every ostensible symptom denoted the character of the case. Its malignancy could not be questioned. The existence of disease in the more important vital organs was sought for. The heart-beat was normal, though, of course, feeble. There was some chronic cough, and traceable signs of chronic bronchitis existed; but beyond this, as far as could be ascertained from that physical examination which the position and condition of the woman permitted, no other morbid signs were discernible. It could not be positively asserted that such did not exist, but Dr. Fleming did not feel himself justified to investigate too closely, by stethoscopic examination, such a case, when the slightest motion was productive of distress in the fractured arm. In the abdomen Dr. Fleming sought for disease, and found a tumour in the umbilical region fixed in its position. In it there was present a pulsation which was distinctly noticed, and which communicated to the stethoscope alterations in sound according to the amount of pressure exercised. That the tumour was behind the aorta was manifest, and that the aorta merely coursed over it, was equally so. The abdomen, being flat and flaccid, the tumour could be grasped laterally, and no pulsation existed in any but its anterior aspect. No change in its form was discernible, no pain was referred to this region, neither was any complained of in the spinal column. There was not a symptom of paraplegia present; no lesion of motion; no lesion of sensation. The sphincter ani did its duty; the bladder did its duty, occasionally slowly, and irritably, but not more so than advanced age and constrained position would account for. The urine was fairly secreted, as to amount, and its qualitative analysis betrayed no unhealthy deviation. All those points are of vast interest when the pathological appearances are considered in this case.

The cast Dr. Fleming stated to be an accurate representation of the seat of the fracture in the sternal end of the clavicle; of the situation of the subclavicular tumour, and of the deformity attendant on the fracture of the humerus. The fracture of the clavicle was found to be perfectly united, the section of the bone presenting in its vicinity that morbid change in its structure usually denominated cancerous. The tumour beneath the clavicle lay under both pectoral muscles; the tissue of the lesser being expanded into a thin membranous shred, it had no connexion with the clavicle, was irregularly nodulated on its surface, remarkably dense and solid throughout, and possessed the characters hitherto assigned to scirrhoid cancer. It was as if incorporated with the subjacent ribs near their cartilages, and appeared to grow from their structure, being there soft, yielding, and expanded; their inner surface was roughened with a similar growth. It would appear as if the origin of the tumour was from the interior of those ribs, and that it rapidly advanced from their inner and outer aspect, becoming consolidated throughout in its growth.

A section through the large swelling at the lower end of the arm exposed a circumscribed bag of grumous blood, intermixed with broken down fibrine, which crumbled under the fingers; within this were to be seen the fractured ends of the humerus—sharp and spiculated, and apparently fused down, so that the normal length was diminished to the extent of not less than from an inch and a half to two inches. The muscles around were softened and atrophied. The morbid change bore much resemblance to that malignant fusion of bone, described by Lobstein, under the name of osteo-lyosis. A longitudinal division of the shaft of the bone presented morbid appearances similar to those above noted. Throughout the substance of the lungs and on their surface, were scattered irregular masses of a similar character, and there was considerable serous effusion into the cavity of each pleural sac, the integrity of each being destroyed by plastic adhesions. The right lobe of the liver contained deposits similar to those above described. In the intestinal tract there was not discernible any appreciable morbid lesion; neither was any to be detected in the urinary or genital organs.

On examining the tumour alluded to in the lumbar region, another large mass was found, as seen in the preparation and drawing presented to the Society. It grew from the fourth lumbar vertebra, the body of which was completely transformed into structures of a similar character, and posteriorly a portion of this projected towards the spinal canal, diverting its channel somewhat laterally, but not encroaching on its calibre. The aorta was remarkably displaced by the tumour, being projected forwards, and thrown over to the right side. On dividing the adjoining vertebræ, masses of the same morbid deposit were found in some isolated and distinct blocks, whilst in others it was irregularly infiltrated throughout; no doubt could be entertained as to the origin of the disease in the bones of the vertebræ exhibited, and the growth of the abdominal tumour from that locality. In the adjoining vertebræ were also visible circumscribed masses of the same character. Dr. Fleming directed attention to the several points of practical interest in the case, and especially to the universality of the disease, so characteristic in the osseous system. The fact of the absence of mammary or of uterine cancer formed no unimportant item, and was particularly worthy of remark, when the recorded instances of constitutional cancer were borne in recollection. In most if not all of such recorded, the breast, the testicle, or the uterus had been the primary affection. In the case of Neilan, it is not easy to determine whether or not the bones were primarily engaged; a very rare circumstance indeed. At all events, no symptoms were noted until the occurrence of the spontaneous fractures. All were subsequent to them. The remarkable features of the tumour in the abdomen were deserving of comment; and the absence of any nervous lesion consequent upon its situation was equally so. Drawings and preparations were exhibited illustrative of the implication of every class of bone with cancer, in its circumscribed and infiltrated form, in the cases of two females, the subjects of atrophied mammary cancer. The particulars of these cases were detailed as recorded in the collection of the Richmond Surgical Hospital Museum, and they most satisfactorily exhibited the progress and the effects of this formidable disease when engaging the bones.

The several preparations and drawings exhibited illustrated these several details most satisfactorily.

The cases were those of a woman (M'Tager), aged sixty-three, who died in the Richmond Hospital, under the care of Mr. Adams; and Dr. Fleming believed almost every bone in the body was the seat of the disease. A second remarkable case was brought under the notice of the Society by Dr. Smith, in the session of 1841.

In conclusion, Dr. Fleming alluded to the histology of the disease in Neilan's case, and the many difficulties now apparently connected with the subject.

Dr. Lyons examined the different specimens, and states that, at the seat of fractures in the clavicle, there was a deposit similar in general and micrological characters to that in the other bones and in the tumour; but that it is, in his opinion, "a peculiar form of disease, and not cancer."

Dr. Fleming asks—Are the deposits in the liver, cancer?—and what are those in the lungs?

SELECTIONS FROM FOREIGN JOURNALS, &c., &c.

On the Treatment of Vaginitis and Leucorrhœa. By MM. Becquerel and Rodier.—In this paper the authors detail the results of a comparative trial of various local applications they have made at the *Lourcine*. The following are their conclusions:—1. The application of *concentrated solution of nitrate of silver* is very painful, not infrequently inducing exacerbations that compel the suspension of the treatment. The same objection applies, though in a much minor degree, to the *solid nitrate*. 2. *Tincture of iodine* possesses few advantages; for, although it causes little pain or exacerbation, its power is feeble. It is, however, a good means for dissipating either recent or old leucorrhœa, when unaccompanied by an inflammatory condition of the mucous membrane. 3. A solution of *tannin* in equal parts of distilled water, and applied directly to the inflamed mucous membrane, is the best means of treatment, exciting neither notable pain nor exacerbation, curing, apparently without fail, and as promptly, as the solid nitrate of silver. So efficacious and unirritating, indeed, did the authors find this concentrated solution of tannin, that they now employ it in all cases, acute or chronic.

During the discussion which ensued upon reading the paper, M. Becquerel laid down the following marks of distinction between the *varieties of vaginal flux*:—1. The discharge consists in a pure, transparent, viscous mucus, composed of mucine, diluted in water, containing very small quantities of saline matters. It is furnished by the uterus when quite healthy, and sometimes when slightly irritated, but not to the extent to produce inflammation. 2. *Leucorrhœal mucus* is milky and opaline, containing some bubbles of air. It contains mucine, salts, and fat, especially cholesterine. Under the microscope, we find abundance of epithelial cells, and some fatty globules. It is never a product of inflammation, and is often coexistent with an anæmic condition of the mucous membrane. 3. *Muco-pus* is thick, viscous, and of a light or greenish-yellow colour. It contains mucine and fatty matters in great abundance, but no soluble albumen. By treating the fluid with a little water, shaking and filtering it, we obtain a liquid that is not coagulable. Under the microscope, we find fatty globules, with a few epithelial cells and pus globules. It is the product of inflammation of the mucous membrane, but without ulceration. 4. *Purulent mucus* consists of a mixture of muco-pus and pus. It infers the existence of ulceration, and it often presents us with a means of diagnosis when there is ulceration of the mucous membrane of the interior of the cervix uteri, inacessible to the eye. It contains little mucine, abundance of fat, especially cholesterine, and soluble albumen. The presence of this last is shown by agitating a little of the fluid with distilled water, the filtered liquid being coagulable by heat. Thus the fluid that is the product of simple inflammation contains pus *without* albumen, whilst the result of inflammation with ulceration contains pus *with* albumen. With the microscope, we observe in purulent mucus numerous pus globules, a few epithelial cells and fat globules, and proteic granulations.—*L' Union Médicale*, 1855, Nos. 7 and 13.

On the Effect of certain morbid Agents in producing Coagulation of the Blood in the living Body.—Mr. Henry Lee read some cases before the Medical Society of London, of obstructed circulation in the heart and large vessels. The principal symptom observed during life in all the cases was a peculiar difficulty of breathing, which Mr. Lee regarded as in some degree diagnostic of this affection. This symptom was so urgent in the cases related that it had prevented the patient sleeping for several days and nights. It appeared suddenly, evinced a disposition to recur in paroxysms, and was accompanied by œdema or some other indication of obstructed circulation. In the first case related these symptoms had appeared in 1852, and the author had then mentioned the case to the Society as one in which he believed obstruction of the pulmonary artery had taken place. The patient, however, recovered, but during the last year the symptoms recurred as at first, and the patient died. Two fibrinous concretions were found attached to the heart, one connected with the right auricle, the other with the right ventricle. The first was very small, but firm and tough, apparently of long standing; the second extended through the pulmonary artery, taking an exact mould of the semi-lunar valves, and followed the ramifications of the pulmonary artery. With the formation of these two concretions Mr. Lee associated the two attacks to which this patient had been subjected. In another case the patient had been long subjected to cough and oppression as the chest, when in a single day, and without any apparent cause, the eye-lids and cheeks became considerably swollen; at the same time the forearms and lower extremities became œdematous: there was a soft murmur with the first sound of the heart, and a double murmur was heard in the vessels of the neck. In the left lung the vessels of different diameter were observed, on a *post-mortem* examination, to be completely filled with concretions having the form of ramified cylinders these were white or light brown, solid, and exactly moulded to the vessels. They were, in some situations where they but partially filled the vessels, surrounded by a semi-fluid black blood. The left ventricle contained a fibrinous concretion, adhering slightly to the apex of the heart. A conical concretion occupied the right ventricle. This extended into the pulmonary artery, taking an exact mould of the semilunar valves.

In a third case the difficulty of breathing had lasted only thirteen days, when it proved fatal. This patient got very little sleep during the whole of this time, and as long as possible continued in a sitting posture. Four days before death the left leg and foot were found to be cold and livid. Upon dissection, the popliteal artery was found firmly obstructed by a coagulum, which had apparently been conveyed there from the left ventricle of the heart; for this contained several other coagula in various stages of softening. The cellular tissue around the obstructed popliteal artery was condensed.

In the cases related the author regarded the disease as originating from some morbid matter in the blood, and illustrated this position by detailing the effects of injecting pus from an acute abscess into the circulation. A preparation was exhibited showing the extensive coagula which had been produced in this way, and the general disposition and appearance of the coagula thus produced artificially have a somewhat striking resemblance to those which had been found in the case first related, and which were exhibited at the same time.

Mr. Lee concluded that several morbid agents besides pus might determine this separation of fibrine from the other constituents of the blood, and that probably among these might be classed some kinds of fat in a state of degeneration and tubercular matter.

Theory of the Formation of Bone.—M. Flourens, the justly eminent Professor of Comparative Physiology at the Natural History Museum of Paris, is now giving his usual course of lectures on this important branch of medical studies. From the report of these lectures, given in *L'Union Médicale*, we extract the following interesting facts connected with the theory of the formation of bone:—

"The *external* periosteum mainly contributes to the *formation* of bone; but the *internal* periosteum (medullary membrane) is the principal agent in the *absorption* of bone. Around the dead portion of bone an internal periosteum forms, belonging to the new bone, which periosteum seizes, and, as it were, gnaws and corrodes the old bone, and finally causes its absorption. (Does not the purulent matter issuing from the fragments carry off a good deal of osseous detritus?) In general terms, in the healthy bone, the internal periosteum may be looked upon as an apparatus chiefly designed for *resorption*. The mechanism of the development of bone appears to consist in a constant mutation of the parts composing it; hence we have mutation of matter, permanence of form. Buffon very justly said, 'The most constant and the least variable fact in nature is the *form* or *mould* of each species, and what is most variable and corruptible is *substance*.' Bonnetus, with all the physiologists of his time, believed that the growth of bone was effected by the deposition of new molecules between the old ones; but we now know that bone is not a fixed and constant substance, but one successively and uninterruptedly formed of superficial layers, which become again re-absorbed. Hence the fallacy of the theory of accumulated germs."

It is now perfectly known and acknowledged that the periosteum may act as the regenerator of bone. We shall just adduce a case of the late Blandin, mentioned in these lectures, which offers a good practical illustration of this theory.

The patient was a young man between twenty-five and thirty years of age, affected with caries of the clavicle. Various means employed to arrest the disease having failed, M. Blandin, encouraged by the experiments of Flourens, resolved to remove the sternal half of the bone, which had been most damaged by caries. By careful management he succeeded in removing the bone without injuring the periosteum more than by the necessary longitudinal incision. This done, the acromial end of the bone was, at the request of the patient, carefully examined and found equally diseased. The latter insisted on having that portion also removed, which operation was performed in the same manner as the first. The patient recovered, and having returned to the hospital for another complaint, about eight months after this complete extirpation of the clavicle, it was found that the bone had been completely regenerated. (It is difficult to understand how a bone can be carious and its periosteum perfectly healthy.)

On the Radical Cure of Hydrocele by Injections of Chloroform. By Professor LANGENBECK, of Berlin. —Not being satisfied with the effects of tincture of iodine as an injection in cases of hydrocele, the above surgeon has recently been employing chloroform as a substitute for it with excellent results. He finds that it acts in the same manner as Tinct. Iodinei, but that it sets up adhesive inflammation more quickly and more surely than that remedy. After withdrawing the fluid of hydrocele, he injects ʒi. or ʒiss. of chloroform through the canula, and after allowing it to remain for a short time in contact with the tunica vaginalis, he allows it to escape, so as to avoid its absorption. The pain occasioned by it is not intense,—even less so than that induced by iodine,—and it is not of long continuance. Langenbeck, in his paper, relates the particulars of four cases treated thus, in all of which a complete and radical cure was accomplished in from two or three weeks.—*Deutsche Klinik*, 31, 1835.

Inhalation of the Fumes of Opium in Coryza.—Dr. Lombard, of Geneva, has found that in those severe cases of coryza which are accompanied by great pain and sense of weight in the frontal sinuses, the inhalation of the fumes of burnt opium affords the patient the most marvellous and speedy relief. The pain ceases as if by enchantment, and the patient passes from a state of misery into one of comfort. Dr. Lombard recommends a few grains of powdered opium to be thrown upon a slip of metal, previously heated in a spirit lamp; and the patient is desired to hold his head over, and forcibly to inhale the fumes of the drug.—*Gaz. Méd. July*, 1854; and *Bull. Gen. de Thérap. 30th August*, 1854.

Cyanuret of Mercury.—M. Desmartis, of Bourdeaux, after a careful comparison of the effects produced by the different preparations of mercury, has come to the conclusion that the cyanuret is superior to all others, especially in syphilis. He believes it to be at the same time efficacious and innocuous in its action; he never saw it occasion salivation or any intestinal irritation; and often, when all the preparations of the metal had failed to produce benefit, he has seen it restore to health patients whose cases seemed hopeless in the extreme. He has found its use to the efficacious in certain cases where the patients had suffered, for a long period, obscure pains, for which no cause could be discovered. He has employed it with benefit in iritis, and in syphilitic affections of the nose and fauces.

DUBLIN: PUBLISHED BY W. B. KELLY,
8, GRAFTON-STREET.
LONDON: S. HIGHLEY, 32, FLEET-STREET.
EDINBURGH: MACLACHLAN & STEWART.
April 1, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.

SENT FREE BY POST.

Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 6.—Vol. II. APRIL 15, 1855. Price 5d.

MEATH HOSPITAL AND COUNTY DUBLIN INFIRMARY.

Clinical Lectures.

BY MAURICE HENRY COLLIS, M.B., F.R.C.S.

Mammary Abscess.

I intend to bring before you this morning the subject of Mammary Abscess, in connexion with some cases which you will find in the Surgical wards. Upon this subject a good deal of confusion exists in the minds of students, and in the majority of elementary books which are in their hands. The cause of this confusion is to be sought in a want of accuracy in diagnosis. The various situations in which inflammation may arise, and matter form, in the mammary region, are frequently not adequately isolated in books, or in the minds even of practising surgeons; hence the anomaly of opposite lines of treatment, each of which is upheld strenuously by those that advocate it. Some surgeons never open an abscess in this region; others open them always, and at an early period. Some vaunt the efficacy of constitutional treatment, or of local depletion, while as many reject all such means as useless or injurious. Where such controversies exist between practical men, the truth will be found to lie between the extremes. In the present instance, a glance at the anatomy of the region will give us a clue to it.

Commencing with the integument, we find that in the areola which surrounds the nipple, a number of sebaceous glands lie imbedded in its substance, or extending into the adipo-cellular layer which lies immediately under it. This fatty layer varies, of course, in thickness; under it we find the ordinary dense fascia, which in this situation is of considerable strength, and forms a portion of the capsule of the gland; from the deep surface of this fascia, prolongations pass through the gland, radiating somewhat from the nipple, where they are most dense and evident around the milk ducts; they subdivide the gland into lobules, and can be traced into the investing membrane of even the ultimate acini, of which it is made up: they are attached, but by no means so firmly as in front to the deep fascia, which lies close to the pectoral muscle. Indeed, there is frequently a kind of bursa developed in the cellular tissue behind the gland, which was first described by M. Nelaton. This deep fascia and the capsule of the gland are intimately united, where they come into contact along those borders of the gland which lie parallel to the fibres of the pectoralis major. Along the borders which cross the muscle, the attachment is more loose and cellular, I suppose for the purpose of allowing free play of the muscle. There are a multitude of other anatomical facts connected with this region to which it is not necessary to draw your attention, as those which I have stated suffice to explain the varied phenomena of mammary abscess.

There are three distinct situations in which inflammation and abscess may be found here:—

1. Superficial to the capsule of the gland.
2. Within the capsule.
3. Parenchymatous.

Each of these presents varieties, which it will be necessary to glance at.

1. The superficial inflammation may be con-

fined to the sebaceous glands of the areola. This form is like acne in any other situation, very chronic, slow to suppurate, not painful if it be not handled or irritated, generally multiple, and requiring a gently resolvent treatment in its early stages. When matter forms, it then will be advisable, unless the patient object strongly, to make a minute puncture before the skin is too much thinned; the cure is thus rendered less tedious, and the subsequent cicatrix less perceptible. Thin, unhealthy persons are most liable to this furuncular abscess, and your general treatment will be regulated accordingly. Of all these particulars we had, some time ago, an example in a patient under my care, who lay in bed No. 30. You may remember how she improved upon tonic treatment and generous diet. Another and more important variety of superficial abscess is that of the adipo-cellular tissue, which differs in no respect from abscess in the same tissue elsewhere. The excited condition of the gland, which precedes and follows parturition, is frequently the cause of a succession of these superficial abscesses. In this case cooling aperient medicines, with local fomentations of poppy-heads, will be found useful. As soon as matter forms, a free incision should be made, lest sinuses should form, as they sometimes do, by the matter burrowing through the capsule of the gland. If the abscess is single, it resembles a boil in every respect, and occurs independent of parturition. You have an example of this in the woman who lies in bed No. 26. You saw how large and prominent the swelling was, and how distinct the fluctuation. The tumour had a hard, shining red base, and lay quite superficial to the gland. The sufferings of this patient were considerable, and her relief upon a free evacuation of the abscess was instantaneous, the sac rapidly contracted, and in less than a fortnight she has completely recovered.

We now come to the second situation which inflammation may occupy, namely, within the capsule of the gland. Of this there are also varieties. A rare and extremely severe form is diffuse inflammation under this capsule. The early symptoms are important, as delay in active treatment will lead to extensive sloughing. The whole breast is swollen considerably, the increase of size laterally being remarkable. Still there is no prominence or bulging of the breast in whole, or in part; it is a flat broad swelling, with great œdema of the integuments, which are not much discoloured; the pain is intolerable, with great deep throbbing, but not much heat of surface; the constitutional distress is great, and the fever quickly takes a typhoid form. These are all symptoms of severe inflammation of a diffuse character under strong fascia, and the treatment is accordingly by free incisions through the fascia, if possible before any matter has time to form. The vessels are thus unloaded, and gangrene, by strangulation, prevented. Fortunately this is a very rare affection. I recollect to have seen one case only. Among the externs last year, a woman presented herself with the symptoms that I have enumerated; contrary to advice, she refused to come into hospital and have the breast lanced. She did not return for four days, when the integuments covering the gland had gangrened, leaving a slough the size of my hand to separate. This will give you some idea of the danger of neglecting proper treatment in the early stages of diffuse inflammation of the breast.

Another situation in which matter may form within the capsule is in the lax cellular tissue behind the gland, or in the bursa which is found there when the breast is pendulous; this is generally complicated with fistulous abscess through the gland, or more properly between its lobes; either may form first, and neglect of a simple subcutaneous abscess may lead to the matter burrowing through the gland. When matter forms under the gland we find it preceded by ordinary inflammatory symptoms, especially foul tongue, heat and dryness of the surface, rigors, and general malaise, which will continue for three or four days; the breast is enlarged and prominent, but without any distinct tumefaction of one part above another; the surface is hot and shining, with a little enlargement of the cutaneous veins. After a few days' continuance of such symptoms, some œdema appears in the integuments over and round the breast; if the general symptoms continue, with slight exacerbations at night, we have sufficient evidence of the formation of deep matter, of which there is generally a large quantity in this situation; should there be no appearance of softening on any point of the surface, a free depending opening should be made behind the gland, that is between it and the pectoral muscle. Even if the matter has made its way forward, either through the gland or along the margins where the deep fascia is only loosely attached to the capsule and the gland, and requires to be opened in front, it will not be possible to empty the cavity at the back without a counter-opening below, and an attempt to do so will almost infallibly lead to the formation of a sinus. In the early stage, before matter has actually formed, the use of leeches placed round the base of the breast will be found occasionally attended with benefit; it is, however, to calomel and tartar emetic that you are chiefly to trust, leeches seldom do more than limit the severity of the inflammation, and hasten the formation of a smaller quantity of pus. Should sinuses form, they must be freely opened, if possible in a depending position, so that all matter may escape; supporting the breast also assists, and, in the more chronic states, compression by bandage, with injections of a gently stimulating nature, such as weak solutions of nitrate of silver or weak tincture of iodine : at best, however, the affection is most troublesome.

I now come to the third class of abscess, the parenchymatous or genuine milk abscess. Whether this occur as a result of mechanical obstruction of the lacteal ducts, or of inflammation of the proper substance of the gland, it is almost invariably connected with parturition. It is also said to be the commonest of all forms of mammary abscess; it certainly gives rise to more pain and distress than any other abscess, perhaps than all others. It is characterized by great hardness and swelling of the gland, great heat and pain, of a throbbing nature, great tenderness, not much inflammatory fever, rather irritability and nervousness. The abscess points slowly near the nipple, and whether left to itself or opened by the surgeon it furnishes but little matter; the inflammation frequently spreads to neighbouring lobules, and the patient is tormented with a succession of abscesses. The best treatment, in the early stages, is a diligent use of local means to prevent suppuration. General antiphogistics have no effect; even cooling purgatives must be used with caution. Leeches have little efficacy, I believe, I might say no efficacy at all. Frequent hot stupes of poppy-head or camomile infusions, gentle friction with warm oils and tincture of opium, rest in the horizontal posture, with support to the breast, are most effectual. A very good way of applying heat is by boiling small wooden bowls in water, and when they are well heated applying them to the breast, wrapped in flannel. Should these means fail in preventing the formation of pus, they ought not to be discontinued; for, as I before stated, the inflammation is apt to creep from one lobule to another, and its spread may yet be checked. Unless there be some very decided indication, such as great pain, the knife should not be used in this form of abscess ; and if used the incision should be a mere puncture. By a free use of the knife, we wound the glandular parenchyma, open into the interbobular areolar tissue, and help to spread the mischief. The collection of matter is never large, a teaspoonful or two in general; and it is surrounded by a thickened and inflamed glandular tissue, which must be divided before the matter can be reached. Nature effects the opening of the abscess through the thinnest part of its wall, namely, through the side of a milk-duct, near the nipple. This position has the further advantage of drawing the inflammatory action away from the deeper parts of the gland, and in a safer direction.

In conclusion, I would only remark, that the anatomical situation of inflammation and abscess of the breast gives us both a means of division and a guide to diagnosis and treatment. Abscess in the areolar tissue, whether superficial or beneath the fascia, preserves the character and requires the treatment of abscess similarly circumstanced in other parts of the body; while the genuine parenchymatous abscess of the breast is, to a certain extent, *sui generis ;* it presents an example of inflammation of a special nature, such as we can only study in the breast, and requires to be treated by rules drawn from experience of itself alone.

WHITWORTH AND HARDWICKE HOSPITALS.

Case of Cerebro-Spinal Meningitis, with Observations.

BY DOCTOR BANKS.

A. M., æt. 16, was admitted into the Hardwicke Hospital on the 13th February, 1855. She had been in the enjoyment of perfect health until two days before admission into the hospital. On the evening of the 10th, having sat for some time at an open window, she was *suddenly* seized with shivering, headache, pain in the abdomen, and vomiting. The surface of the body was cold, and there was extreme prostration of strength. During the night she became delirious, having previously complained of severe pain and stiffness of her neck. The following day the symptoms continued, but with augmented intensity.

She complained of a sensation of noise in her ears and giddiness, and she was utterly unable to move her head. The vomiting was almost constant, the least movement invariably brought it on. When received into hospital, she had recovered from the state of collapse into which, according to the report of her friends, she had so suddenly fallen on the evening of her seizure.

The face was flushed, the forehead deeply corrugated, the neck stiff, and the head bent back. There was intolerance of light; inability to distinguish objects; strabismus of both eyes, which are half closed; pupils contract on the approach of light; pulse 140; respiration rapid; no evidence of thoracic disease ; tongue dry and loaded; bowels confined; no urine passed since accession of disease; pains and stiffness of the legs; impossibility of assuming the erect posture; increased sensibility of the whole surface of the body; 14th, she passed a most restless night; short and uneasy snatches of sleep, and loud screaming on awaking. This morning there is a partial restoration of vision, but the objects appear double—strabismus continues. She complains much of the pain in the back, along the spine, the slightest pressure upon which is intolerable.

On the evening of this day, herpes appeared in great quantity over various parts of the body—the forehead, lips, the right arm and leg, &c., &c.

15th.—A more tranquil night; pulse 120; respiration less rapid; still complains of pain in head and neck, and inability to move; but the pain in the back is much less intense; still double vision.

16th.—The report of this morning favourable; little pain of head, neck, back or legs, except on attempting to move; no intolerance of light, but vision still double.

From this period the symptoms underwent a slow but steady amelioration. On the 21st all trace of the disease had disappeared, and with the exception of extreme debility she expressed herself as feeling almost well.

To those who had opportunities of observing cerebro-spinal meningitis when it appeared as an epidemic in this country in 1846, it will be evident that the case above related presents a group of symptoms which sufficiently proves its identity.

Differing in no very material point from the recorded cases of the disease in its epidemic visitations, it presents one feature which, as far as I am aware, was not observed in the Irish epidemic of 1846, for which reason, as well as from the comparative rarity of such cases terminating in recovery, I have deemed it worthy of a passing notice.

A glance at the history of the disease will be necessary to connect this case with this formidable epidemic to which I allude.

Cerebro-spinal meningitis invaded France in an epidemic form some time before the year 1839; it first appeared at Bayonne, subsequently in 1839 it appeared at Rochfort, chiefly among the inmates of the convict prison, and afterwards attacked many other localities.

At first the disease was supposed to be a kind of typhus, and by some physicians, particularly by M. Boudin, it was considered the same malady, typhus cerebro-spinal, which had prevailed in Grenoble and Paris in the year 1814.

I apprehend a review of the various epidemics, the history of which has been recorded with much accuracy by many eminent cultivators of medical science, among whom I may mention Tourdes, Forget, Faure-Villar, Lefevre, and Dr. Mayne of this city, will satisfactorily demonstrate the untenableness of this opinion.

In all the epidemics the reported cases presented the same leading characters. A remarkable uniformity may be said to have characterized them. The lesions of the nervous and muscular systems were all-sufficient for diagnosis.

In some particulars, both as regards the commencement and the progress of the malady, as well as the class of persons attacked, there have been some notable differences observed.

First, touching the mode of attack, in many instances it has been sudden, as in the girl who forms the subject of these observations; she was, to all appearance, in the full enjoyment of health when she was stricken down.

Dr. Mayne informs us, that "in four of the cases at the South Dublin Union, the boys had eaten a hearty dinner, and retired to bed in apparent health, when the disease all at once declared itself." The suddenness of the invasion has been the subject of comment by many Continental physicians.

According to M. Tourdes, many were seized "tout à coup au milieu de la santé la plus parfaite." This, however, has not always been the mode of attack, and hence we find certain diseased conditions which preceded the invasion, described under the name of precursory symptoms. Much difference has been noted in the amount of the disturbance of vision. In the case I have detailed, there was utter inability at first of distinguishing objects, and subsequently, there was double vision. It appears that this is rather unusual. M. Valleix says—"La vision est rarement abolie; on a constaté tout aussi peu frequemment la diplopie, et les cas sont peu nombreux ou il y a eu affaiblissement ou aberration de la vue."

In the case I have recorded, there was a copious eruption of herpes on the face, and on other parts of the body; this, I believe, was not present in any of the cases observed in the epidemic of 1846 in Ireland. Dr. Mayne does not mention it, and he refers not merely to the cases under his own immediate care, but to the account given of the disease by Dr. Darby, of Bray, who first made known the existence of the epidemic in Ireland. He had before him, also, the able report of my colleagues, Professor R. W. Smith and Dr. M'Dowel, who were commissioned to inquire into the circumstances connected with the disease as it appeared in the Belfast Union.

Much importance has been attached to the appearance of the herpetic eruption, inasmuch as the mortality has not been quite so great in the cases in which this phenomenon was present, as in those in which it was absent.

As to the sex of persons who are the subjects of cerebro-spinal meningitis, all agree in assigning to the male, beyond all comparison, the greater frequency. Females are rarely attacked, but it has been ascertained that the mortality has been greater ("en revanche") among them than among men.

The most interesting facts connected with the epidemic cerebro-spinal meningitis refer to the class of persons seized. In Ireland, almost all were boys, and under 12 years of age. In France, it was chiefly seen in persons from 20 to 30, and in some of middle age.

The researches of those who have enjoyed the most extensive means of acquiring information on the subject have shed no light upon the etiology of this disease. Not one of the so called predisposing or occasional causes has been operative in a vast number of cases.

The girl, whose case I have called attention to, was not subjected to any of the supposed causes. Here was an isolated case, with all the characters which distinguish the disease in its epidemic visitations, without any apparent cause, except the casual exposure of the person to cold. This, however, is not singular; we now and then meet a solitary case of pestilential cholera, bearing all the signs which so eminently distinguish the disease when it exists amongst us as a widespread pestilence.

The mortality in the epidemics of cerebro-spinal meningitis has been greater, I believe, than in almost any other disease. Such being the fatal nature of the complaint, we anxiously look for the results of treatment in arresting its fearful ravages. Many different modes of treatment have agreed in being equally impotent when brought to bear upon the disease. Some of the plans put into execution were not, in my opinion, calculated to lead to anything but disappointment.

The amount of blood which has been caused to flow, in the treatment of cerebro-spinal meningitis, is dreadful to contemplate.

M. Chaufford, after repeated failures with bleeding, &c., &c., had recourse to opium, and of this remedy he speaks in terms of high praise; in this he is followed by some, while, on the other hand, the same favourable results have not been experienced in the practice of other physicians.

The course of treatment pursued in the case which I have so lately had under my observation, was one which, I believe, is most likely to find favour with British physicians. When brought under my notice, the stage of collapse had passed, reaction had been established. The head was shaved at once, blood to a *moderate amount* was taken from the back of the neck, and subsequently, by leeches, from the temples, tepid water was frequently poured upon the head, and on each occasion with manifest relief to the symptoms. Mercury was introduced into the system, at first in the form of Hydrarg. cum Cretâ, gr. iij. every second hour, and afterwards, with a view of more rapidly inducing its action, mercury was also used endermically. At a later period, blistering was resorted to. The duration of the disease,* in its intensity, was shorter than usual, but the subsequent debility was great, and the convalescence proportionably protracted.

ON CANCER, AND A FORM OF THIS DISEASE WITH BENIGN CLINICAL FEATURES.

BY ROBERT D. LYONS, M.B., M.R.I.A., &c.

[Read before a Meeting of the Pathological Society, Wednesday Evening, February 28, 1855.]

(*Continued from page* 75.)

Rejecting the criterion of special histological elements, it will be found exceedingly difficult to establish, in anything like an absolute manner, the exact nature of any particular morbid growth. Writers on cancer have failed hitherto to furnish us with any sign or group of signs which may be considered pathognomonic. I speak of course now from a strictly scientific point of view, but one which it is absolutely necessary to bear well in mind, if we are ever to hope for any satisfactory solution of all the difficult questions of diagnosis involved in the consideration of cancer.

M. Velpeau will not rely on the results of the microscope. He admits the cure of cancer, claiming no less than twenty-two cases rescued by himself; but as there is no definite standard to appeal to, it is not to be wondered at that all observers do not agree in his diagnosis in several instances; and here, be it observed, that this difference of opinion is not confined to the advocates of a special histology. Clinical surgeons have expressed dissent from the decision of M. Velpeau as to the cancerous nature of all his cured cases. I am not going to enter on a discussion of the particulars of his operations, but I wish to draw attention to two forms of disease classed by him under the head of cancer, but which, as I think, do not fall necessarily within this category. One comprises some of the forms of mammary tumour described by him, in which infection did not take place; the other, that singular and highly malignant, I would even say frightful disease, which he terms the *squirre en cuirasse* in which the integument of a more or less extensive part of the body, abdomen and chest, becomes thickened, breaks, and becomes fissured, and, finally contracting, encloses the unfortunate patient in an ever-diminishing corslet of hide, till death puts an end to the torture of the sufferer.

I have seen one example of this disease, in a much modified form certainly, and of greatly less extent than in M. V.'s cases, but though it is undoubtedly a highly malignant cutaneous affection, I see no reason for regarding it as cancer.

It is but one of an extensive class of diseases, differing widely in seat and structure, which have the common clinical feature of malignancy, variously expressed it may be, but which, beyond this, present no other resemblance than that they have a greater or less power to produce suffering, interfere with vital processes by their mechanical effects, and in some instances, resisting all modes of treatment hitherto proposed for their alleviation, lead to a fatal result, and that often with great rapidity, and with the production of much suffering. On the other hand, cancer, that *malignant* disease *par excellence*, as it is usually regarded, is sometimes met with pursuing its course with apparently little disturbance to function, and but little, if at all, interfering with structure. Its course may be even of considerable duration, extending over many years: and it may present a total absence of suffering. We have already seen by the statements of Walsh, Herrick, and Popp, that infection is by no means a necessary condition in cancer.

I have myself, on several occasions, seen examples of undoubted cancer, which wanted many of the so-called malignant features; but in many respects the most remarkable of the kind that I have met, is the case with which I purpose briefly to occupy your attention on this evening. It is one which presents several very remarkable features; it was unquestionably, in my mind, an example of genuine cancer, yet in its progress it failed to exhibit several of the characters usually associated with this disease.

The patient was aged thirty-seven. At the time I saw him, the disease had been in progress somewhat more than a year. He had enjoyed excellent health, and was not aware of the existence of any disease, until, having been tripped one day in the street by a dog, he shortly afterwards noticed a small tumour on the inside of the left groin, which subsequently increased in size, but gave him little pain. Indeed, with the exception of the inconvenience caused by its gradually enlarging dimensions, he had no cause of complaint whatever. Advice, however, was sought, and the question of the propriety of operation was entertained; but a second opinion having been taken, it was finally determined to allow matters to follow their own course.

At a subsequent period, I saw the case, when the following observations were made, which I transcribe from my note-book. The patient was pale, sallow, and emaciated. The tumour had steadily increased in size, until, when measured over its greatest prominence, the limb was found to be two feet one inch in circumference, the opposite one in a corresponding situation being but 17½ inches. The tumour occupied the inner and anterior parts of the upper two-thirds of the left thigh, was of a uniform oval shape, its elevation from the surrounding parts being gradual and regular. It was excessively hard, but entirely free from pain, and could be manipulated and examined most minutely through its whole extent without producing the least suffering. The skin, covering it, was smooth, a little shiny, quite devoid of any irritation, and colourless, except where a few small veins coursed through it. The femoral artery crossed the tumour on the outer side, and could be felt with ease. A small circular, moveable, painless tumour existed above the crest of the right ilium, and was apparently confined to the integuments.

Casting the eye on the trunk, as the patient lay uncovered, it was manifestly unsymmetrical; there was an extensive uniform and regular enlargement of the left side, occupying the left infra-mammary region, encroaching a little on the epigastrium, and extending through the left hypochondriac region to the back; it also passed downwards towards the ilium. On manual examination and percussion, it was found that one or more solid tumours existed in these situations. He said that he some days previously experienced uneasiness in the epigastrium, but it was only temporary; his chief suffering was altogether from flatulence: the urine from time to time presented a good deal of purpuric deposit. The chest was generally resonant, the respiratory movements tranquil, the heart's action normal; pulse 100. These points will be found worthy of note.

I experienced considerable difficulty in arriving at a satisfactory conclusion as to the nature of these tumours. The absence of pain, of any tendency to ulceration, the patient's indifference to any kind of manipulation, the normal condition of all the vital organs, the freedom from local or general suffering, the entire absence of any of the so-called malignant characters—for throughout, the clinical features of the disease were as benign as those of any form of tumour that I am acquainted with—made it a matter of great difficulty to pronounce a positive diagnosis. If the tumour had been confined to the limb, I should probably have fixed on the idea of enchondroma; if to the abdomen, on some form of the simple fibrous or lipomatous tumours which we know are capable of reaching a vast size. But this is not the place to discuss all the bearings of the question of diagnosis in such a case.

The progress of the disease from this period was steady, and unmarked by any incidents worth noting till towards its close.

The tumour in the thigh gradually but sensibly increased in size; the enlargement of the abdomen went on from day to day, and the tumour or tumours—for it was yet impossible to decide whether there were more than one or not—began to cause some uneasiness, merely, however, from their size, and from their consequent mechanical interference with the organs around them. The colon could be traced nearly through its entire course, but, especially in the transverse portion of its arch, thrust forward before the mass, and often thus imprisoned between the latter and the wall of the abdomen. Constipation and flatulence now caused more suffering than the patient had at any time before experienced.

His appetite continued pretty good, but he was much emaciated, for the whole vegetative force of his system appeared devoted to the supply of these immense growths. The abdomen at length became so large as to render the poor patient quite unwieldy to himself, and he lay on his back unable to turn and hardly able to move.

A little dyspnœa had been complained of from time to time, but with relief of the abdominal flatulence this generally disappeared too. Of late, however, it became increased, and was pretty constant. On one occasion a paroxysm of dyspnœa came on, and after a couple of days of rather severe distress of breathing with symptoms referrible to the left lung, I contrived to effect an examination of the left side of the thorax on the lateral and posterior aspects, a thing by no means easy of accomplishment, as it was almost impossible for him to sit up. Dulness on percussion was found as high as the infrascapular region behind and the fifth rib in front. Coupling this with the paroxysm of dyspnœa, cough, and other symptoms referrible to the left lung, and as I had now for some time regarded the case as one of cancer, I concluded that cancerous deposit had taken place into the left lung. How far this conclusion, from such symptoms and signs, was warranted may, perhaps, be questioned now; but it also admits of doubt, whether we have arrived at any principles of physical diagnosis capable of deciding what the actual state of parts is under similar conditions. I may here first briefly state, that in the case in question it was not what I supposed. As will be seen in the sequel, cancer had been deposited within the thorax, but not in the organ, nor in the manner in which I was led to believe.

It will be unnecessary to follow the case in further detail; suffice it to say that the disease progressed steadily, and the tumours continued to enlarge gradually but sensibly. To the end the only suffering was from flatulence, the sense of tension and distention in the abdomen, and occasional dyspnœa.

In about a year and a-half from the first date of the disease, or rather, to speak more accurately, from the period at which the small tumour in the groin was first noticed, he died somewhat suddenly.

I examined the body with much interest and attention.

The tumour in the left thigh was found to be one uniform mass, of oval figure, smooth on the surface, entirely unbroken, free from any connexion whatever with surrounding parts, and easily detached from them; it had passed in deep, so as to reach the neck and shaft of the femur, but there was no mark or erosion of any kind on the bone, which in all respects appeared perfectly healthy, and the growth but lay in contact with it.

On opening the abdomen, a tumour of enormous dimensions came into view, partly obscured by the colon which ran in front of it and was attached to it; the lower part of the peritoneal cavity was filled with extravasated blood. The tumour was found to be one continuous solid mass, reaching from the diaphragm to the groin, moulded on the spine but free from it, as it appeared to be from everything with which it lay in contact, as the intestines, the liver, the spleen, and above all, the left kidney, which was enclosed in a kind of cleft in the tumour, and flattened out to the shape and dimensions of a hand, but in all respects healthy, and its peritoneal covering uninjured.

I examined with care for the source of the effused blood, and can only suppose the hæmorrhage to have taken place in the following way, by rupture of veins, and thus I believe to have been the immediate cause of death.

The colon, as I have stated, lay in front of the tumour, so did the omentum and part of the meso-colon, both of which were thus compressed between the tumour and the wall of the abdomen, and in consequence their numerous vessels had undergone distention to an enormous degree, and when this distention was carried beyond a certain point the veins had given way, had poured their blood into the peritoneal cavity, and had thus caused death, for the quantity of blood effused was very considerable.

I directed particular attention to this great tumour, with a view to determine if possible from what point it had sprung; but this I was quite unable to do; it was connected only with the mesentery, for though it touched almost every part and organ within the abdomen it had no connexion with any of them. There was no disease of the lumbar glands, no deposit in the liver, spleen, or kidneys, and all these organs were in a perfectly healthy condition.

On opening the thorax, the lungs were found quite healthy; no inflammation, congestion, or deposit of any kind existed in them. The left pleural cavity was, however, greatly diminished in size in the vertical direction, the left ala of the diaphragm being thrust up before an immense lobe of the great abdominal tumour, so as to be on a level with about the fifth or sixth rib. This enlargement had probably taken place in this direction with some rapidity, hence the sudden paroxysms of dyspnœa, and hence, also, the absolute dulness and absence of respiration at the infrascapular region, and up to the fifth rib in front.

And here I may call attention to what I conceive constitutes an unsolved problem in physical diagnosis. Given, dulness and absence of respiration on either side of the chest, with an immoveable diaphragm from whatever cause, enlarged liver or spleen, or tumour such as that now under consideration: required, to determine the condition of the intra-thoracic organs.

But I have said that there was a cancerous deposit within the thorax. Though not into the lung, a deposit had taken place into the heart; a mass of a square form, and about two inches in diameter, was impacted in the wall of the left ventricle, projecting into the pericardial sac: but however long or short a time it had existed in this situation, I never had the least suspicion of such a deposit, nor was there in the action of the organ any one abnormal condition to draw attention to it, though I had repeatedly examined it with care.

On section, these several tumours presented as *beautiful* an appearance as I have ever met with in dissection of such structures. The surface of section was of a rich cream colour, lightly tinted with the delicate lemon yellow one often sees in cancer, the whole looking like the section of some rich, ripe fruit. The substance was pretty firm and homogeneous throughout, and these appearances were almost identical in all the specimens. The histological elements were, I may briefly say, those of cancer, exhibiting cells, nuclei, and other elements agreeing with those of cancer in all respects. That this remarkable disease was cancer no doubt remains on my mind, though to prove to an absolute demonstration that it was such is, I believe, hardly possible, except to those who admit the existence of special histological elements.

If we take a survey of the chief features of its clinical and anatomico-pathological details, we shall find that it wants several of the characters assigned to what we may term the normal type of cancer, or cancer *selon les regles*.

At no one period did it present a single symptom or character which could be called MALIGNANT.

Confining ourselves to its clinical history, its course was undoubtedly BENIGN, for it did not ulcerate, it caused no pain, it simply grew with a vegetative force.

Taking the phenomena presented during life at any given time, they could be readily explained by supposing, for example, that the tumour in the thigh was an enchondroma, and that in the abdomen some accidentally co-existent indifferent growth, a fibrous one for instance. Other equally obvious explanations will occur to your mind.

Looking to its pathological results, we find these also very singular: it attacked no neighbouring structures; it lay on a bone, and did not erode it; it enclosed, compressed, and flattened out a glandular organ, such as the kidney, and yet in no way invaded its structure. I know not how to trace any anatomical or physiologico-pathological connexion between the seats of the primary and secondary growths; in what relation the groin, the mesentery, and the left ventricle of the heart stand to each other, I am at a loss to conceive. The ordinary channels of communication, the blood vessels, or the lymphatics, could not have been the medium of transit of the germs of the disease; neither the lumbar glands, nor the liver, nor the lungs, which are so often the points of arrest, were here in the least degree affected; there was not then, in this case, secondary infection or deposit in distant organs, that great criterion of cancer diagnosis in the ordinary sense. This, usually regarded as perhaps the most highly MALIGNANT and fatal feature in true cancer, was wanted in the case before us.

From the absence, then, of the various characters usually denominated malignant, and from a consideration of the mild clinical features presented by the case through its whole course, I have used what may seem a bold, if not unwarrantably hazardous figure, and called it an example of Benign Cancer; malignant it was not, in any sense of that ill-used word; it was fully as innocent or benign as any of the tumours known as such, and I have taken advantage of these facts to associate the term Benign with that of Cancer. This I have done advisedly, and not without a purpose. I believe that the slovenly language which is so often used to cloak ignorance or imperfect diagnosis, and for this purpose employs the word *malignant* to tie together several diseases essentially different, betokens a slovenly pathology worse than useless, for it is an immediate impediment to the advancement of our science. I have contended against it, and I hope to see it soon exploded.

It is often asked me, when a specimen of disease is put into my hands for examination, whether it is "malignant" or not, to which I always reply, "THAT is a question to be answered by the clinical history of the disease, but it is entirely outside the province of pathological anatomy." A disease may be highly malignant, like the eroding cutaneous ulcer or the *squirre en cuirasse*, and yet not be cancerous; and I believe a growth may be found to be Cancer histologically, and yet to have exhibited a comparatively Benign course in all its clinical features.

The diagnosis of the so-called MALIGNANT diseases has been cast as an opprobrium against the faces of the rising school of scientific pathologists, because they cannot reduce an equation essentially complex in its nature and the number of its terms, to a popular expression intelligible to those who will not go deeper than the *a b c* of our science. With the words BENIGN CANCER, to use a term warranted by the days in which we write, I throw a shell into the opposite camp, the explosion of which will, I trust, help to carry away the mists of doubt, error, and unscientific pathology which cloud round the word MALIGNANT.

DISEASES OF THE SKIN.

From the French of M. Maurice Chausit.

BY J. K. BARTON, A.B., M.B., T.C.D., &c.

M. Chausit's *Traité Elémentaire des Maladies de la Peau*, contains an account of all the recent improvements introduced into the classification, diagnosis, and treatment of diseases of the skin by the French school, particularly by M. Cazenave. He informs us in his title page, that his work is, *d'apres l'enseignement theorique et les leçons cliniques de M. le docteur A. Cazenave*, and it is, in fact, throughout a faithful and concise record of the theoretical views and practical experience of this great physician.

M. Cazenave does not put forward his new or natural classification of skin diseases as complete. He, on the contrary, declares it as yet imperfect; but he has formed the plan and raised the walls of the superstructure, leaving it to his own future experience, and the labours of others, to complete the building. Nor can this new classification, as yet, *entirely* supersede the artificial system of Willan and Bateman; but we may feel confident, that when, by future observations, it becomes perfected, it will take precedence of all others. The student of Botany, while he acknowledges the extent and accuracy of the observations of Linnæus, no longer thinks of employing his classification. So the student of Practical Medicine, while he appreciates the labours of former authors, will gladly avail himself, in studying the diseases of the skin, of a classification which, in *every* name, tells him something of the nature and cause of the malady he is examining. It is to be hoped that *skin diseases* may thus cease to be the most puzzling and distasteful part of their studies to students, and the very *terra incognita* of their profession to practitioners.

In addition to his labours in arranging and classifying, M. Cazenave has directed his attention to the study of the best means of treating every form of skin disease, and the records of his experience in this respect form one of the most valuable parts of M. Chausit's work.

In his introduction our author says :—

"M. Cazenave has occupied himself with great care in the discovery and definition of the various causes which preside over the development of the diseases of the skin. These he has divided into three principal classes :—

1st. *External causes.*

2nd. *Internal causes.*

3rd. *Constitutional causes.*

"The *external causes* are all of those which act directly on the skin, such as heat, cold—the contact of certain substances, topical irritants, &c.

"The *internal causes* are evidently the most numerous, the most important, and also those which, in general, are most difficult to appreciate. Without mentioning the predisposition to disease resulting from a collection of physiological conditions, which it is not possible accurately to determine, but amongst which are to be placed the peculiarities of constitution and temperament, *internal causes* comprehend all the functional disorders of the viscera, reacting on the skin by means of a sympathy more or less pronounced. It is thus that, in a great number of cases, cutaneous affections are connected with disorders of the gastro-intestinal mucous membrane, of the liver, uterus, &c.

The *internal causes* include also, all the influences which may profoundly debilitate the economy,—such as grief, privations, excess, overwork, &c.

The *constitutional causes* relate to the constitution of the skin itself: they are exclusively confined to this organ, and refer to no malady beyond the one there expressed. They are sometimes acquired; but more frequently exist in the original conformation of the skin: they almost exclusively give rise to lesions of the epidermic secretion, i.e., to the scaly affections.

"If we bring these ideas to the study of treatment, we will immediately perceive the exact and useful indications to which they lead.

"When the disease of the skin arises from an *external cause*, then it constitutes an affection purely local or accidental, and the treatment consists in the application of topical remedies and in the administration, perhaps, of some simple medicine internally, but is altogether directed to removing the immediate cause.

"When the eruption is the result of an *internal cause*, first of all it is necessary, in order to discover the origin of the disease, to examine the previous history of the patient, then to study the actual state of the constitution, to discover the existing state of the functions, to examine the different organs, to determine, in fine, the functional disorder upon which depends the eruption, and then to combat this with suitable remedies. This research is by no means easy, and it often happens that the attention of the physician is drawn aside by the accidental disease which preoccupies his mind, and he forgets the general state of the constitution which has given rise to it. In cases of this kind the treatment consists principally in the employment of internal means. With regard to topical remedies, they are, without almost any exception, quite inefficacious; sometimes giving rise to real inconvenience from the irritation they cause.

M. Cazenave is accustomed in his clinical lectures to insist upon the necessity of being very cautious in our employment of these means, whenever we have to deal with a disease of the skin which depends upon a general derangement; and when it is necessary to have recourse to them, to employ the simplest and least active we possess.

"When the eruption is the result of a *constitutional cause* (i. e. a structural disease of the skin itself) topical remedies would naturally appear to be particularly indicated. Yet, whilst they do not here present the same objections as in the last-mentioned class, they are far from producing the good effects which we might expect from them. It is still to internal treatment we must have recourse in these cases. But here we have no longer any guide to rational treatment, and hence must look to the teachings of empiricism. We hasten, then, at once to declare, that the preparations of arsenic and ammonia exercise upon the skin certain physiological effects, which experience universally confirms, and which explain, up to a certain point, the decisive good effect which they often produce in this form of disease."

After this M. Chausit proceeds to give M. Cazenave's first table of classification, which appeared in 1841, and then, after some remarks, his second or improved table. Instead of following our author in this, however, I will copy the table which M. Cazenave submitted to his hospital class last year, and which, containing the latest improvements suggested by the experience of the author, differs in some few particulars from that given by M. Chausit:—

Classification of M. Cazenave.

First Group. *Inflammations.*	First Class. Eruptions (non specific) which exist either in an acute or chronic form.	Erythema. Erysipelas. Urticaria. Strophulus. Herpes. Eczema. Pemphigus. Impetigo. Ecthyma. Sycosis.
	Second Class. Eruptions (non specific) which exist always in a chronic form.	Rupia. Lepra. Psoriasis. Pytiriasis. Pellagra.
	Third Class. Eruptions specific & acute.	Roseola. Measles. Scarlatina. Variola. Vaccinia. Varicella. Miliaria.
	Fourth Class. Eruptions specific & chronic.	Syphilitic. Eruptions.
Second Group. *Lesions of Secretion.*	First Class. Lesions of the follicular secretion.	Acne. Porrigo Favosa.
	Second Class. Lesions of the Epidermic Secretion.	Icthyosis. Horny Productions.
	Third Class. Lesions of Secretion of the Colouring Matter.	1st. *Discolorations.* Albinism. Vitiligo. 2nd. *Coloration.* The bronze tint. Ephilides. Pigmentary Nævi.
Third Group. *Hypertrophies.* (An abnormal development of the affected part.)		Elephantiasis (of the Arabs). Molluscum. Frambœsia. Verruca. Vascular Nævi.
Fourth Group. *Degenerations.* (With a tendency to destroy the parts affected.)		Elephantiasis (of the Greeks). Button (of the Alps). Keloides. Lupus. Cancer.
Fifth Group. *Hemorrhagic diseases.* (Maladies characterized by the presence of blood more or less altered outside the vessels which ought to contain it.)		Purpura. Melanosis.
Sixth Group. *Lesions of the Sensibility of the Skin.*		Hyperæsthesia, Lichen. Prurigo. Anæsthesia.
Seventh Group. *Foreign bodies.*		Scabies. Pediculus. Pulex.
Eighth Group. *Maladies of parts annexed.*		1st. Diseases of the hair. 2nd. Diseases of the nails.

In this classification we find the diseases of the skin divided into eight primary groups or natural families, viz.:—1. inflammations; 2. lesions of secretion; 3. hypertrophies; 4. degenerations; 5. hæmorrhagic maladies; 6. lesions of the sensibility of the skin; 7. foreign bodies; 8. diseases of the annexed parts.

The first group is subdivided into four distinct classes:—1. composed of non-specific diseases, which exist either in an acute or chronic form; 2. the non-specific, which exist in a chronic form only; 3. specific diseases, which exist always in an acute form; and 4. specific diseases, which exist always in a chronic form. The second group consisting of lesion of secretion naturally divides itself into three classes, viz.:—1. lesions of follicular secretion; 2. lesions of epidermic secretion; and 3. lesions of the colouring secretion, this last being subdivided into discolorations and colorations.

The third group includes diseases which consist in an abnormal enlargement of some part of the skin. The fourth, in contradistinction to these, is made up of diseases in which degeneration of some or all of the cutaneous tissues has taken place, ending usually in the destruction of the affected parts. The fifth group is characterized by the presence of blood more or less altered outside the vessels which ought to contain it, and is named the hæmorrhagic group. The sixth group is one of peculiar interest, for in naming the diseases included under this head, *diseases of the sensibility of the skin*, a great step is at once taken from considering the external marks of disease as the malady itself, to pronouncing them only the signs or effects of a deeper and more subtile lesion. The seventh group of diseases are those which are found to be caused by some substance foreign to the economy, either animal, vegetable, or mineral, which, attaching itself to the skin, excites diseased action there. The eighth group includes the maladies of those parts which, though not strictly belonging to the skin, yet are conveniently and properly considered with them, viz., the diseases of the hair and nails. The manner in which some of the diseases are grouped under these heads will, doubtless, cause some surprise, but of this M. Chausit must be allowed to speak for himself.

(*To be continued.*)

PATHOLOGICAL SOCIETY.

February 19th, 1855.

THE PRESIDENT, MR. ADAMS, IN THE CHAIR.

Aneurism of the Arch of the Aorta; Ossification of the Sac.

DR. STOKES laid before the Society a remarkable specimen of aneurism of the arch of the aorta, which presented the peculiarity of the sac being extensively ossified, and made the following remarks on the case. With regard to the history of the case there was very little known, but even that little, when we consider the extensive destruction of organs which has taken place, is interesting. Up to the period of his decease the man had the character of perfect health; he was strong and muscular, a ship-carpenter by trade, and was in the very act of proceeding to his day's work, when he fell down, throwing up a torrent of blood, and then died.

He had, for some time, complained of cough, and had occasional hæmoptysis, but as to the amount of blood which he lost, or the nature of the cough, there is no record; but it is enough to say, that it never disabled him from attending to his duties.

The aneurism had sprung from the arch of the aorta, and had burst by a large opening into the œsophagus. The amount of ossification is very remarkable; the orifice is perfectly rigid, and when the sac is struck, it gives the peculiar ringing sound of a bone. The osseous plate was slightly broken in the removal of the parts; and but for this, the sac would be completely shelled with bone. The œsophagus presented no abnormal appearance, excepting the orifice, which was oval and well defined, communicating with the aneurismal sac. This communication was formed, we presume, at the moment the fatal hæmoptysis occurred: there is no reason to believe that the patient ever vomited blood before; and it is even possible, as has already been sufficiently proved by cases which have been brought before this Society, that the œsophagus may be perforated without causing the death of the patient.

The stomach contained a great quantity of blood.

The heart was perfectly healthy, and rather small. This coincidence has been occasionally observed, and it proves that there is nothing in the mere existence of aneurism in the aorta which would cause disease of the heart, or that an aneurism in that situation throws any additional labour on the left ventricle. This fact also furnishes a very important aid to diagnosis; for, if the concurrence of an hypertrophied heart and aneurism were common, diagnosis would be rendered very difficult, and symptoms greatly obscured; but if we have the heart acting in a regular and normal manner, it is much less difficult to find the second centre of pulsation. We may now say, therefore, that even with an ossified aneurism the heart may not be diseased. He agreed with Dr. Corrigan in his opinion, which indeed no one can now doubt, that the safety of the heart depends on the safety of the valves, and that while they are sound, we may have enormous aneurismal disease without the heart being at all affected; but on the other hand, if the valves are imperfect, the heart becomes immediately diseased.

The ascending aorta is greatly diseased; and in one part presents an appearance like ulceration. There is nothing more difficult than to determine the difference between a false and a true aneurism; and Bizot, who has written a great deal on the subject, is of opinion, that the test of continuity of the lining membrane is of little value, because the sac becomes covered with a false membrane, which unites it with the lining membrane of the artery.

In this case the bodies of several of the vertebræ were deeply eroded; and this is very singular in connexion with the fact, that the patient was able to perform his duties up to the very hour of his decease; and it shows that erosion of the vertebræ may be carried very far indeed without disabling the patient.

Scirrhous Tumour in the Abdomen.

PROFESSOR BANKS detailed the following case, and exhibited the morbid appearances. A woman aged 38, but looking much older, was admitted into Sir Patrick Dun's Hospital on the previous Wednesday in a state of extreme debility. She stated that she had been married at the age of sixteen, and had borne one child, and that her labour had been a most tedious one. Her health had been invariably good until July last, when she had "a difference of opinion with another woman, who knocked her down and kicked her in the belly."

The next day she experienced severe pains in the back and loins, followed by hæmorrhage from the uterus, which returned at intervals, and was so profuse as frequently to require that the vagina should be plugged, ordinary means having failed to arrest it. For twelve weeks she continued to lose blood in considerable quantity, and towards the end of this period she felt pain in the lower region of the abdomen, extending to the sides. About the same time she perceived a swelling in the site of the pain, a solid mass, which she could move about with much facility. The pain became daily more intense, and the tumour, after the lapse of a few weeks, became so firmly fixed, that she found it impossible to move it. There existed a vaginal discharge, which was thin, serous, and destitute of fœtor.

On entering the hospital, this woman presented the appearance of a person who had long laboured under malignant disease, reduced to the last degree of weakness, and complaining of agonizing pain in the abdomen, and utter sleeplessness.

The lower part of the abdomen was occupied by a very large tumour, the upper edge of which, on a line with the umbilicus, was well defined; at either side it could be traced into the iliac regions.

The surface was exceedingly irregular, there being many elevations and hollows; in parts it gave the sensation of stony hardness, particularly above the pubes, to which it seemed to be firmly attached.

The slightest pressure on the abdomen occasioned exquisite pain. Constipation with alternating diarrhœa existed until the close of life. Much of her suffering was occasioned by difficulty of micturition. She could only pass water, and even then almost *guttatim* by elevating and supporting the tumour, and at the same time leaning forwards.

A vaginal examination was made by Doctor Dwyer, the physician accoucheur to the hospital, who found the uterus immoveably fixed. It was, therefore, evident that the malignant growth had formed an intimate attachment to this organ.

Autopsy.—On opening the abdomen, an inconsiderable quantity of straw-coloured serum flowed out. The peritoneum was generally vascular, and lymph had been deposited in the interstices of the intestines, so that in many situations they are closely glued together. The tumour which was felt during life filled a great part of the abdomen, and extended into the pelvis. All the parts in the pelvis, bladder, uterus, and rectum were involved in the cancerous mass. The bladder was contracted into a very small space. A dense solid scirrhous mass sprang from the posterior part of the uterus. In the cavity of the pelvis was a large quantity of broken down cancerous matter, semi-fluid, and resembling somewhat in appearance "puree de pois." The iliac vessels were completely coated with, or bathed in cancerous matter. Cysts, some as large as a walnut, others smaller and filled with colourless fluid, were found scattered through the tumour. A single tubercle, of cartilaginous hardness, was seen on the surface of the liver.

The peritoneum covering the abdominal surface of the diaphragm was studded with small hard tubercles. One kidney was greatly enlarged, and its ureter much distended, but not otherwise abnormal; the other was converted into a mere bag, having altogether lost its natural appearance. The lungs were perfectly sound. The heart was of a pale yellow colour, soft and flabby; fat to an unusual extent had been deposited on the surface, and its muscular tissue had undergone fatty degeneration. The stomach was free from cancerous disease; there was no external cancer.

Dr. Banks observed that the facts reported proved how long life may be protracted in cases of malignant disease, of enormous magnitude and extent, even under unfavourable circumstances. It is difficult to form an opinion as to the original seat of the disease in this instance.

It is probable that the inflammation which involved the peritoneum and the cancerous masses, powerfully contributed in the end towards accelerating the fatal termination which might in the absence of the inflammatory process have been postponed for some time. That life should be compatible with such an amount of disease, and its consequent sufferings, cannot fail to excite astonishment.

Dislocation of the Shoulder Joint; Chronic Rheumatic Arthritis.

Dr. Hughes exhibited a very remarkable specimen of an old unreduced dislocation of the head of the humerus, in which the new articulation had become the seat of chronic rheumatic arthritis. He was unfortunately not able to give any history of the case, as the affection of the joint was not remarked during life. The patient from whom the specimen was removed was a very strong, muscular man, aged 50, and came into the medical wards of Jervis-street Hospital in an advanced stage of typhoid pneumonia, of which disease he died in a few days after admission. The luxation of the shoulder joint was only observed during the progress of the *post mortem* examination. His wife, when questioned about him, was quite surprised to hear there was anything wrong with his shoulder, as he had always been a hardworking man, his occupation being that of a porter; and for the last eleven years she had been married to him she never heard him complain of any affection or pain of the arm, nor did she know that he had ever received any injury of the part; neither was he a single day during that period unwell or obliged to leave off work. Professor Smith had very kindly taken the trouble to examine the joint, and he was indebted to him for the following description of the diseased parts:—

The original glenoid cavity, much smaller and shallower than natural, has assumed a triangular form, the base of the triangle being above; its surface was, for the most part, covered by an adventitious membranous structure, derived from the margin of the glenoid ligament, which, although much altered from its normal appearance, was still very distinct and strong, and marked most clearly the limits of the original socket.

The new articular surface for the dislocated head of the humerus was formed upon the costal surface of the scapula, below and to the inner side of the coracoid process; it was placed exactly at a right angle with the glenoid cavity, the inner margin of which it formed, and here the glenoid ligaments accurately defined the limits of the normal and abnormal sockets, between which it formed an abrupt boundary; the greater part of the surface of the latter was smooth and polished as ivory, and its margin was surrounded by membranous fringes of considerable size, but particularly large and numerous at the upper part of the joint, just beneath the coracoid process. This process formed a portion of, and was continuous with, the new articular surface, the most superior and anterior part of which it constituted.

The head of the humerus, much enlarged, greatly deformed and flattened from before backwards, occupied the situation in which it is usually found in cases of luxation forward; the greater portion of it lay to the inner side of the coracoid process, with the inferior surface of which it was in contact; it formed a tumour below the clavicle, and was covered by the greater pectoral muscle; as much of its surface as was in contact with the false socket was smooth and polished, but throughout the rest of its extent it was extremely irregular and nodulated.

The greater tuberosity had become an articular surface, continuous with that of the head of the bone, and the tendon of the biceps ceased at the summit of the bicipital groove, where it was closely adherent. In the recent state, all the obstructions composing the new articulation were extremely vascular. The original socket presented none of the characters of the rheumatic disease, which were so evident in the newly formed joint.

SELECTIONS FROM FOREIGN JOURNALS, &c., &c.

Atropin in Epilepsy.—Dr. Lange of Königsberg tried this remedy in nine cases of epilepsy, in three of which the patients were males, and the remainder females. The three male patients, who had been epileptics for years, were cured after its employment for periods varying from three to six weeks. Among the women two cases remained uncured; one patient died; and three seemed cured, as they had been free from attacks from five to eleven months. The dose used was scarcely one-tenth of a grain.—*Deutsche Klinik*, 10, 1854.

Communication of the Left Ventricle with the Right Auricle. By Dr. Buhl.—Dr. Buhl relates the case of a girl, aged nineteen, who had suffered almost from birth from palpitation, dyspnœa, and cyanosis. When visited a short time before her death, the following physical signs were noticed: considerable bulging of the thoracic wall, on a level with the second rib; dull percussion-note over the whole sternal region, from the second rib downwards, and on either side, to half an inch outside the nipples; pulsation over the whole front, more on the right than on the left side; marked systolic thrill, more marked also on the right than on the left side; marked systolic murmur on the right side, with its maximum close to the sternum, on a level with the fifth cartilage; moderate fulness, without undulation of the cervical veins; slight visible pulsation of the carotids, but of no other artery. On section, the right auricle was found of enormous size; the left auricle was extremely small; the left ventricle was somewhat hypertrophied; at the upper part of the septum the muscular substance was transformed into a thick fibrous tissue, in the middle of which was an oval opening (one-and-a-quarter centimetres long, half a centimetre broad), surrounded with a firm cartilaginous ring, and leading into the right auricle, immediately above the insertion of the tricuspid; the aortic valves were thin; the right ventricle was dilated; the tricuspid valve greatly thickened, particularly near the point where the opening existed; at this point, also, it was rigid, shortened, and therefore incompetent; the calibre of the pulmonary artery was increased, that of the aorta much narrowed; the jugular veins were not remarkably enlarged. This condition sufficiently explains the physical signs.

During the systole arterial blood must have been mixed in large quantity with the venous blood in the right auricle; during diastole a small quantity only of venous blood would pass from the auricle into the ventricle, as the entrance into the right ventricle was so easy. Professor Buhl points out, that in this way the arterial was less contaminated with the venous blood than the venous with arterial blood, and he conjectures that the transmission of blood already surcharged with oxygen through the lungs may have produced the dyspnœa; as if it had been surcharged with carbonic acid. If the dyspnœa was not owing to this cause, it must have been to the pressure of the heart on the lungs.

The cause of the opening is referred, not to congenital defect, but to inflammation and ulcerformation in the ventricular wall, occurring during fœtal life, or soon after birth; and the observations of Dittrich are referred to, who had remarked that an abscess at this point of the heart might cause a communication between the left ventricle and the right auricle.—*Henle's Zeitschrift für Rat. Med. and Medico-Chirurgical Review.*

On the Absence of Typhus in the Tropics, and in the Southern half of the Earth. By Dr. M—. In an interesting paper, this anonymous writer passes in review the various evidences found in writers which show that the European typhus is unknown, or almost so, in the tropics and in the southern hemispheres. He appears to be extremely well read in English literature, and draws many of his illustrations from English authors. He has not even omitted the late observations on the occurrence of three cases of typhoid fever in Burmah, by Mr. Scriven; but he considers these to be doubtful. His conclusion is, that " Typhus is a disease only of the northern temperate zone, and that its southern limit is the isothermal line of 72 deg. Fah.; it does not occur in the southern temperate zone, or at any rate it is not endemic there."—*Henle's Zeitschrift für Rat. Med. and Medico-Chirurgical Review.*

Injections of Chloroform-vapour into the Uterine Cavity to relieve Pain. By M. ARAN.—M. Aran, extending the local application of the vapour of chloroform in uterine affections, recommended by Dr. Hardy, of Dublin, has adapted to Dr. Hardy's apparatus a hollow uterine sound, pierced at the end by two openings; this is passed into the uterine cavity. Caution is advised not to inject the vapour too suddenly, lest the uterus be distended; but done gradually, it is said that instant relief is given to uterine pain. Five cases are reported: in three the effect was favourable; in one of these, a case of post-puerperal metritis, pain was completely suspended, and on a second injection altogether stopped; in a second, a case of chronic metritis, with an irritable condition of the uterus, two injections produced a permanent amelioration; in the third a case of retroflexion, in which the intra-uterine pessary could not be borne, after a few injections the instrument could be worn for several days at a time. In the two other cases, the effect was not so marked: in one, of retroflexion with chronic inflammation, the injections at first caused great pain, it is supposed, from being forced too rapidly, but relief followed; in the other, of obstinate dysmenorrhœa with colics and nervous phenomena, relief was but momentary, whilst the injection of a few drops of laudanum into the uterine cavity gave ease which lasted for twenty-four hours.—*Bul. de Ther., Jan.* 1855, *and Med. Chir. Review.*

Observations on Painful Atrophies of the Mamma, Cirrhosis Mammæ, and Atrophic Sarcoma. —Dr. Wernher, of Giessen, in an excellent clinical contribution to the pathology of the female breast, says that he has seen very many tumours of the breast which so closely coincided, in outward appearances, with scirrhus, that they would certainly have been declared scirrhous, and treated accordingly, but which minute microscopical examination showed to want all the elements of cancer, and to consist entirely of the tissue of the mamma in a peculiar atrophic condition. These observations induced him to examine a series of tumours in the Giessen Museum, part of which belonged to the collection of Soemmering, and described as " extirpated cancers with successful result." To his astonishment, he found in most of these the same appearances as those described above, as having occurred to him in recent cases.

The disease is never seen but in elderly women, who have passed the fortieth year. It was always seen in one breast only, the other being quite sound. The diseased breast did not differ much in size from the healthy one, sometimes it was less full. Round the nipple there was an oval roundish tumour circumscribed. To the feel it appeared a hard knotty mass, which plainly included the whole glandular substance, but perhaps scarcely the fourth part of the circumference of the breast. In the remainder of the breast, at the edges and basis, nothing was found but fat. The diseased gland, as compared with the healthy one, was clearly contracted into a smaller space. The tumour was freely moveable on the pectoral muscle, but closely united to the skin in the vicinity of the nipple. Here the skin was plainly thinned, free from fat, and its motion over the gland was completely lost. The colour was like that of the other breast. The nipple was harder, more knotty, and sometimes drawn inwards in funnel-shape. In one case, even the axillary glands were swollen. The tumour was always very painful; the pains came on spontaneously by fits and starts, were shooting, worse and better according to the weather, and extending towards the axilla and arm of the diseased side. The general condition varied: in some it was altogether favourable, or only disordered through sleepless nights; in others there were complications apparently unconnected with the affection of the breast. Microscopical investigation first freed the author from his error that these tumours were scirrhous. (The microscopical appearances are figured and several cases minutely detailed). He is disposed to assimilate this condition of the breast to that known as cirrhosis in the liver.—*Zeitsch. für Rat. Med. and Medico-Chirurgical Review.*

A Case of Cancer of the Pulmonary Artery. By Dr. A. Wernher.—A man, twenty-two years of age, came under observation with a large and rapidly-growing encephaloid tumour of the knee and tibia, for which amputation was recommended but had not been performed, when, on January 27th, five days after the patient was first seen, he was attacked with sudden pain in the cardiac region, just to the left of the sternum, with dyspnœa, and rapid respiration. Auscultation and percussion disclosed no signs. On the following day, the pain extended to the right side; there was no cough or expectoration, no cardiac palpitation, increase of precordial dulness, or murmur. The pulse was 140. The following night there were many severe attacks of dyspnœa, in which the pulse was scarcely to be felt. On the third day after the attack, some pure coagulated blood was coughed up, and on the following day, a smaller quantity of blood was expectorated. Two or three days subsequently, the dyspnœa diminished, and the patient passed nearly into the same state as before the attack.

All this time the tumour of the knee had been growing, and on the 7th February, amputation was performed. It was found to be an exquisite specimen of encephaloid;—but we pass over its microscopic characters. On the following day there was much fever, and on the 10th February, a return of hæmoptysis. The febrile symptoms continued, and these was increasing weakness till the 19th, when there was shivering, and dull percussion-note of the bases of the lungs. On the 20th and the following days, very frequent cough, serous, bloody, offensive sputa, mucous râle all over the lungs, shivering, heat, miliaria. On the 24th, death occurred, with the symptoms of asphyxia and profound collapse.

On *post-mortem* examination, the iliac and crural veins and their branches were normal, not thickened, and without coagula; the vena cava was also perfectly healthy. The heart was healthy. The pulmonary arteries, on the other hand, contained coagula of coherent cancer-masses, forming fibres and strings of dull-white colour, like boiled rice, which strings were composed of many thinner ones, closely pressed together. These masses filled almost all the branches of the right pulmonary artery; the left pulmonary artery contained also many, but was freer. The walls of the vessels were normal in most cases; in some these were incorporated with the contained cancer-masses. The smaller branches were dilated from the pressure of the massses. The capillaries and pulmonary veins were perfectly free. Under the microscope, the masses were found to be made up, almost thoughout, of cells, exactly like primary cancer-cells, large, oval, with one or two nuclei. In the blood of the right heart, and of the vena cava ascendens, precisely similar cells were found. Nothing similar was found in any other blood.

Besides this, there were large gangrenous abscesses in the lungs; and it was noticed that the arteries leading to them were particularly obliterated by the cancer-masses, and that the vessels in their wall were in the same state.

There was no trace of either young or old tubercles.

This singular case, then, consisted in primary cancer of an extremity and secondary cancer in the branches of the pulmonary artery; and all the facts seem to show that the cancer-cells passed as such from the primary growth, through the medium of the venous blood, to the right side of the heart, and then into the pulmonary arteries. A general infection of the blood is negatived by the fact that nowhere, except in the direct track of the venous blood coming from the tumour, were cancerous masses found. In fact, an infection of the blood, a general cancerous disease, does not appear to have gone before the primary local manifestation in the tibia. Dr. Wernher, we may remark, pauses at this place to argue against the hypothesis of a general cancerous disease, or cachexia, preceding in any case, local disease; and urges that the cancer is in fact first a local one, like syphilis, and that the general cachexia is entirely secondary.

In the case now related, it would appear that after the removal of the tumour of the leg, the secondary cancer of the pulmonary artery grew very rapidly.

Dr. Wernher then compares the symptoms of his case with those of cancer of the lung given by Walshe, and finds a remarkable similarity, except that there was superadded gangrene, from the blocking up of the arteries.—*Henle's Zeitschrift für Rat., and Medico-Chirurgical Review.*

On Ulceration of the Frænum of the Tongue in Hooping Cough. By Dr. Gamberini.—The very frequent existence of little ulcers on the frænum of the tongue in hooping-cough has been noticed by two or three observers. Since 1844, Gamberini has looked for its presence in all the cases seen by him; he finds it generally, but not always, present, even in the most severe cases; the ulcer has seldom a round form; usually it lies transversely across, and cuts the frænum; it may be placed on the inferior surface of the tongue, near to, but not on, the frænum; it is never preceded by a vesicle, but commences at once as ulcer. Gamberini thinks this ulcer is produced mechanically, by the projection and laceration of the frænum against, and by, the teeth during the violent paroxysms of cough; it is in those cases in which the tongue during the cough is not carried against the teeth, but is retracted somewhat towards the pharynx, as sometimes happens, that the ulceration is absent.

If the incisor teeth are of unequal height, the ulcer exists only, or is deepest, at the point where they project most. In one case in which the teeth had not appeared, there was no ulcer. In other cases of convulsive cough, Gamberini has not found the ulcer, but he does not regard this as militating against his explanation of its origin.

On the External Uses of Conein.—Conein (or Conia) as most of our readers are aware, is an oleaginous fluid, which is the active principle of hemlock. Murawjeff, a Russian physician, has found it to be efficacious in the following diseases:—(*a*). In chronic skin diseases it allays irritation and favours the cure. He has used it successfully in eczema, psoriasis, acne, lichen, psora, prurigo, &c. He recommends it in favus, and regards it as a specific for that disease when affecting the scrotum. (*b*). In toothache one drop allays the pain more rapidly and effectually than even chloroform. (*c*). In neuralgia and syphilitic pains of the bones, he alleges that it is not a mere palliative but a radical cure. (*d*). In chronic synovitis its use is beneficial, as also in allaying the pain of (*e*) incised and gunshot wounds. (*f*). In scrofulous and rheumatic inflammation of the eyes it speedily diminishes the severity of the symptoms. (*g*). It palliates the pain in scrofulous and cancerous ulcers. The mode of its employment is as follows:—In skin diseases an ointment is used composed of from twelve to twenty-four drops of conein to ℥i. of ung. simpl. or cold cream. The diseased parts having been first rubbed with soft flannel, the ointment is applied to them, and they are then covered with oiled silk and a bandage. In neuralgia he first washes the part affected with spirits of wine, and then applies to it three or four drops of pure conein, covering it thereafter with oiled silk and a bandage. In cancer he mixes the alkaloid with mucilage, and applies it to the diseased surface with the finger, previously covered with a glove. For a collyrium he adds 1-3 drops to ʒvi. of Aq. distil. and ʒij. of decoct. cydonii; and when used as an enema he administers two or three drops in starch emulsion.—*Med. Zeit. Russl.* 17, 1854; and *Schmidt's Jahrb.* 1854, No. 9.

Vapour of Iodine in Mammary Tumours.—M. Eichmann relates the following case:—A healthy woman, æt. 47, none of whose relatives had ever had cancer, received a slight blow on the breast. This occasioned a hard and mobile tumour. After an absence of the catamenia for 17 months, the tumour became painful; smaller glandular enlargements appeared on the breast and extended to the axilla; lancinating pains were felt; the skin became adherent to the tumour, and the sebaceous follicles were distended with blackish matter. The patient refusing to submit to extirpation, M. Eichman applied to the tumour a bag filled with tow, and containing also iodine, which was retained *in situ* by means of adhesive plaster. The iodine was renewed fortnightly. After wearing this bag for a month the patient was greatly improved, and after the lapse of seventeen weeks the mammary enlargement had completely disappeared.—*Gaz. des Hopitaux*, 19th Dec.

Digitalis Pommade in Cases of Hydrocele.—Last spring an Italian surgeon named Bellucci published accounts of five cases of hydrocele cured by the external use of digitalis. Little attention was paid by surgeons to these results; but very recently M. Laforgu, chief surgeon in the *Hopital de la Grave*, at Toulouse, has made trial of the new mode of treatment, and found it to be as efficacious as was alleged by M. Belucci. A man, æt. 60, had a large hydrocele of the right testicle, and being unwilling to submit to the usual operation, besought M. Laforgue to try some other method. Daily friction of the tumour was ordered with the following ointment:—℞. Pulv. folior. digitalis, 6 grammes; axung. 30 grammes; *misce*. The patient was also ordered to wear a suspensory bandage. In a few days the man presented himself completely cured. He had enjoyed excellent health during the process, and had used, in all, 18 grammes of the powder of digitalis.—*L' Union Med.* 30th Sept. 1854.

Mortality of Medical Men.—We find from a memoir read before the Physico-Medical Society of Wurtzburg, by Dr. Escrich, that the average length of life varies in the different professions. From the statistics drawn up in Bavaria, and which coincide with what Casper had already proved, it appears that among the members of the medical profession the highest rate of mortality exists. Three-fourths of the medical men die before the age of 50, and ten-elevenths before 60. Of 1688 medical men in Bavaria in 1852, four only had passed the age of eighty, and of these four none had devoted themselves to the practice of medicine exclusively. The united ages of the oldest ten physicians amounted to 792; whilst the united ages of the oldest ten in each of the other liberal professions, presented the following numbers, viz.:—Roman Catholic priests, 878 years; Professors in the Schools, 875 years; Protestant Ministers, 865; Lawyers, 850 years.—*Bulletin Therapeutique.*

ERRATA.—We find that the case of *Typhus Fever, mistaken for Apoplexy*, detailed at page 71, was communicated to the Belfast *Clinical* and Pathological Society, by P. Lynch, M.D., Physician to the Belfast General Hospital, on the 24th February, 1855.

DUBLIN: PUBLISHED BY W. B. KELLY,
8, GRAFTON-STREET.
LONDON: S. HIGHLEY, 32, FLEET-STREET.
EDINBURGH: MACLACHLAN & STEWART.
April 15, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.

SENT FREE BY POST.

Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE Dublin Hospital Gazette.

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No. 7.—Vol. II. MAY 1, 1855. Price 5d.

RICHMOND SURGICAL HOSPITAL.

Case of Dislocation of the Shoulder Joint. With Remarks.

BY CHRISTOPHER FLEMING, M.D., M.R.I.A.,

SURGEON TO THE HOSPITAL.

Dislocation of Humerus; Intracoracoid; Reduction after Nine Weeks' Displacement.

James M'Grane, aged 56, an ordinary labourer, was admitted into hospital on the 15th of February last, with dislocation of the left shoulder joint, the result of a fall on the hand in the extended position of the limb, whilst endeavouring to protect himself against slipping. He was fully conscious of the injury at the time, heard a snap at the joint, felt considerable pain in and about it, and lost all power over the limb. Next day he applied to a "bonesetter" of repute in the neighbourhood, who failed in relieving him. From his account considerable swelling supervened about the joint, but no discoloration; and subsequently, his principal complaint, in addition to almost complete helplessness, was of some slight numbness in the hand, and shooting muscular pains in the arm, about its centre, for the cure of which he was directed a strengthening plaister, which now encircled the limb. Being a man of rather spare frame, the bony outlines of the joint were well marked, and the features of the peculiar dislocation most unmistakeable. The prominence of the acromion was considerable, and the hollow beneath it so deep, that the closed hand could be almost imbedded within it, and the glenoid cavity easily traced with the fingers. The flattening of the deltoid muscle was equally remarkable, and in searching for the head of the bone, it was visible under the clavicle on the internal side of the coracoid process, and firmly wedged against it. It was influenced in its position by the direction and movements of the elbow, and was evidently covered by a considerable bed of muscle. Here the subclavian hollow was obviously less marked than that opposite, and a line drawn from the centre of the corresponding clavicle along the anterior wall of the axilla to its inferior border was also deeper. The elbow was separated from the trunk, and inclined obliquely backwards in the axis of the displaced bone. The motions of the arm were very limited, and the limb dangling along the side, with the forearm extended on the arm and the hand supine, was rather swung backwards and forwards by scapular movements than otherwise. Elevation of the arm he had no power over; he could lift any weight with the hand, provided it was below the level of his knee, but he could not raise his hand to his head unless he inclined the latter towards the injured side. By comparative measurement in the ordinary mode, made as accurately as was feasible, it did appear as if there was a lengthening on the dislocated side to the extent of about half an inch.

I have extracted this history from notes furnished to me by my resident pupil, Mr. O'Devaine.

The dislocation was obviously that forwards under the pectoral muscle on the sternal side of the coracoid process.

I kept the man under observation for some days, in the interim subjecting the joint to a variety of extensive and extended movements, and employing almost continuously champooing and unctuous friction about it.

On Wednesday, the 28th February, I succeeded in reducing the dislocation whilst the man was under the influence of chloroform, the time altogether employed being less than half an hour. The position of the patient was horizontal and on his back. The ordinary mode of extension and counter-extension by pulleys was used, varying the line of extension from that of the axis of the shaft of the dislocated bone, to that of almost complete parallelism with the trunk. The counter-extension was at first exercised obliquely across the chest, and ultimately vertically as regarded it by a lac passed above the acromion process and the superior costa of the scapula. The necessary precautions were taken to prevent injury to the skin, and at no time could the traction have been said to be extreme as regarded it. The head of the bone was often more prominent in the axilla than could be wished; but by manipulation the artery was thrown aside from any appreciable pressure. The extension was steadily kept up about twenty minutes altogether, and had at the end to be transferred from above the elbow to the wrist in consequence of the slipping of the strap. I carefully watched the changes in the position of the head of the bone, and felt satisfied that some alteration in its original site was produced. When it approached the glenoid cavity, it was deemed prudent to slacken the force of traction, and to try the effect of the heel in the axilla. This was carefully adopted without removing the man from the table, or too suddenly diminishing the extension, the arm being at the same time drawn somewhat across the chest. It was yet evident that the head of the bone was not restored to its normal position. I now grasped the lower end of the humerus firmly with my right hand, and *lifting it as if up towards the glenoid cavity, with the other hand pressed down the acromion process, and fixed firmly the scapula: now suddenly rotating the arm, I felt a sort of glug or chuck, and found the head of the bone replaced.* No local or constitutional annoyance worth noting supervened. The joint was kept at rest, the head supported for some days with Ellis's crutch-apparatus for fractured clavicles, and passive motion was commenced after about a fortnight, when the man left hospital with directions to report his progress.

On this day (4th April), five weeks after the reduction of the dislocation, an opportunity was afforded of examining the limb. The outlines of the joint are perfect, the motions within it limited, but yet satisfactory, especially when the scapula is fixed, and an increasing power is growing up in the limb; some weakness and numbness are, however, complained of on the forearm.

Directions were given for continuous passive movements of the joint, with attention to the fixture of the scapula during them, and frictions with the usual stimulating liniments were ordered to be applied around it.

Remarks.—There are few reflections which more strongly impress the surgeon with the great practical benefits of his profession, than those referring to dislocations, which, from some contingency or other, escaping detection at the period of their occurrence, have at a more or less advanced stage been satisfactorily reduced. By far the most frequent dislocation he meets with is that of the shoulder-joint; and yet it must be admitted, that notwithstanding its very characteristic features, too many cases present themselves, where, from some unpardonable carelessness on the part of the surgeon, or unaccountable apathy on that of the patient, the nature of the injury is not ascertained. Doubtless, complication may attend the accident, which will obscure its diagnosis. Thus, we have met with such cases, when large corpulency so cloaked the joint that its bony delineations must have been more than ordinarily difficult; and we have met with others similar, when large muscular development and superadded effusion rendered them equally faint; but when we reflect on the almost unvarying nature of dislocations in this locality, the case must be very unusual indeed, which would render mistake otherwise than most humiliating. The dislocation under present consideration is the rarer of the ordinary form; it is that, moreover, which is, perhaps, more frequently met with as *old* and *unreduced*, and as an accurate acquaintance with its pathology is all-important to its successful treatment, I make no apology for transcribing the following extract from a valuable communication of Sir Philip Crampton, in the 3rd Volume of the *Dublin Journal of Medical and Chemical Science*, "on the Pathology of Dislocations of the Shoulder Joint," particularly as I mainly attribute to a knowledge of it the favourable result of the above case, inasmuch as the dissection of a similar form of dislocation is there given.

The subject of it was a labouring man, aged 30, or thereabouts. He had been carried into the Meath Hospital with numerous injuries from falling into a lime kiln; and amongst those a dislocation forwards under the pectoral muscle. The dislocation was reduced, and the poor man surviving his complicated accident not many hours, an opportunity was afforded of examining the condition of the dislocated limb, which, with his usual zeal for the advancement of professional science, Sir Philip Crampton did not lose. The dissection was made by the late Mr. MacNamara, under whose special care the patient was, and from it Sir Philip noted the following particulars:—

"The dislocation was unattended with the rupture of any muscle, or the separation of any tendon from its insertion into the bone: by a slight effort the dislocation was reproduced, and the pectoral muscles being removed, the polished head of the bone was now seen lodged on the cervix of the scapula, at the root of the coracoid process, but extending nearly as far as the notch in the superior costa; it had passed out through a rent in the capsular ligament, *over* the *upper edge* of the tendon of the subscapularis, detaching this muscle from its connexion (which at this point is but slight) with the inner face of the scapula, and pushing its fibres downwards, so that they formed a curve which partly embraced the neck of the humerus; *the supra and infra-spinatus muscles were on the stretch*, but had suffered no injury. The cellular substance covering their tendons was deeply ecchymosed, so as to mark their course most distinctly. On replacing the head of the bone, the opening in the capsular ligament, through which it had escaped from its socket, could be distinctly seen. It was formed by a separation of the ligament from *the interior side of the brim of the glenoid cavity from top to bottom; it was bounded at the top by the tendon of the supra-spinatus, and at the bottom by the inferior edge of the tendon of the subscapularis, the rent was continued as far as the root of the lessor tubercle of the os humeri, and was of sufficient extent, but no more, to permit the head of the bone to pass easily through it, the inferior part of the capsular ligament, however* (*the part corresponding with the axilla*), *was perfect.*

"The great blood vessels and nerves lay to the sternal side of the head of the humerus, and were forced a little out of their course. The axis of the head of the bone, in its dislocated position, was scarcely a quarter of an inch higher than the axis of the glenoid cavity."

Very considerable practical value is derivable from carefully analysing the anatomical details given in the above dissection, and still more from applying them to the special objects in view.

The exact site of the rent in the capsular ligament in this variety of dislocation, as contrasted with that in the more frequent into the axilla, is perhaps the most important circumstance to bear in mind, and the recollection of it at the proper stage of attempting reduction may be of no small value. It may materially assist the accomplishment of such, when the articulating surfaces of the joint have been placed nearly *in situ;* and when, by a sort of mechanical adaptation, the opposing muscles being now wearied in their action, the head of the humerus will appear as if to slip through the rent, which previously was not feasible.

It will, moreover, also appear manifest that considerable benefit must arise from a preliminary training of the joint, as was adopted in the case above, for some days antecedent to the attempting the reduction of the dislocation, and that the indications for the carrying out the latter were correctly founded.

The perfect restoration of the several functions of the joint is questionable, as it must be in almost every case of the kind, apart from the disadvantages of the age of the patient in the present instance, and the probable establishment of arthritis more or less chronic in its character.

Scrofulous Tubers in Liver, Kidneys, Mesenteric Glands, and Stomach.

BY ROBERT LAW, M.D.,

PROFESSOR OF INSTITUTES AND CLINICAL MEDICINE, &c.

Thomas Lalor, aged 60, but whose appearance would have led us to suppose him at least 80 years old, was admitted into Sir Patrick Dun's Hospital, under my care, on the 23rd of December, 1854, in an almost moribund state. He exhibited a specimen of extreme wretchedness and emaciation. He complained of distress more than of pain through the abdomen, but could not fix the precise part where his chief suffering lay. His general aspect made us suspect some wasting (if not malignant) disease. Under the influence of this suspicion, we made a very careful examination of the principal organs of the body, but could not discover in any an explanation of his extreme emaciation and exhaustion. Our first impression was, that he had cancer of the stomach, but if this was the case, he had not the symptoms to indicate its involving either the cardiac or pyloric orifice, in which case alone the disease produces such emaciation as Lalor exhibited. He had no difficulty of deglutition to make us suspect that the cardiac orifice was engaged, nor was there any tumour to be felt in the situation of the pyloric orifice, nor vomiting and constipation to indicate contraction of this orifice, nor diarrhœa, the almost equally constant sign of its patulous condition. The thoracic organs exhibited no signs of disease. He had no cough. He only complained that he needed aperient medicine. Lalor had been in hospital six months before, under the care of Dr. Smith, and then only complained that his stomach and bowels were out of order. His appetite was tolerably good, which surprised us the more, as he was so very thin. He evidently derived no strength nor nourishment from his food. His case was one of complete atrophy, but on what it depended we could not venture even a conjecture. The miserable state to which he was reduced precluded the hope of doing more than prolonging his existence by diet. In fact, there was not an indication we could lay hold of to meet with medicine, except the confined bowels, for which we ordered the mildest aperients. His symptoms altered but little till his death, which occurred ten days after his admission; his ancles swelled; he only vomited once just before his death; his stomach always retained his food.

Examination of the Body.—The body exhibited extreme emaciation. There was about a pint of serous effusion into the cavity of the right pleura; the heart was extremely small, much below its normal dimensions; the lungs contained no tubercles; the abdomen exhibited many interesting pathological appearances; the liver and both kidneys were studded on their surface with yellowish white pisiform projecting tubera. None of these exceeded much in size a large marafat pea; there were more of these tubera on the liver than on the kidneys; they were not found deep in the substance of either organ, but were confined to the surface. The glands themselves did not deviate from their normal structure; the tubera were all convex on their surface, and were of a cheesy consistency; the mesenteric glands were very much enlarged, and contained much of this cheesy matter; the appearance of the stomach surprised us much, as we had in vain sought for an explanation of his wretched emaciated appearance in disease of this organ. The pylorus was very much thickened and ulcerated. It resembled very much an ulcerated os uteri. It was neither enlarged nor contracted; it allowed the index finger readily to pass through. A careful examination proved the thickening of the pylorus to depend upon the presence of hard masses in its walls, and which could be easily distinguished by the touch; these, when cut into, presented a cerebriform appearance. The rest of the stomach was quite free from disease. When I presented these morbid specimens to the Pathological Society, I had had them but a short time in my possession, which only allowed me to procure the microscopic examination of the kidneys and mesenteric glands. The section of the kidneys contained in the cortical substance several large growths of a cheesy appearance and nearly circular section. These, when cut, yielded no creamy juice, but a minute scraping, being placed under the microscope, presented numerous cells smaller than pus globules, irregular in outline, dotted all over, and destitute of nuclei. These were considered tubercle cells, and the growth scrofulous. The microscopic examination of the mesenteric glands yielded similar results. The close resemblance that the tubera on the liver bore to those on and in the kidneys, satisfied me that as the latter were scrofulous, so were the former; their projecting and convex surfaces contrasted strongly with the cupped tubera of cancer of the liver, of which we had an opportunity of exhibiting a very remarkable specimen before the Pathological Society. Others, however, were disposed to consider them of a cancerous nature as well as the thickening and ulceration of the pylorus. Undoubtedly if appearances alone, as they presented themselves to the naked eye, were to decide us as to the nature of the lesion of the pylorus, we should have pronounced it to be cancer, while we found it hard to believe that cancer and scrofula should be both in action at the same time. It must also be admitted, that the patient's age favoured the idea of cancer. In order to decide the question, the microscope was again resorted to, and proved the identical nature of all the morbid growths, both in the kidneys, liver, mesenteric glands, and in the walls of the pylorus, that they all contained the tubercle cells, and were all scrofulous.

The case is one of interest on many accounts. It is remarkable that amidst so much disease, there were so few signs indicating the lesion of any particular organ. This remark especially applies to the stomach, for although we know that an amount of disease may affect this organ, and be perfectly latent unless it engages either orifice, still as the pylorus was here deeply engaged, we confess we are at a loss how to account for its latency. The nature of the lesion in this case was peculiar. It is the first of the kind we have met with. It is a rare thing to meet with scrofula at this period of life.

NEWTOWNARDS WORKHOUSE HOSPITAL.

TO THE EDITOR OF THE DUBLIN HOSPITAL GAZETTE.

Newtownards, 14th April, 1855.

Sir,—If you think the following case, confirmatory of an opinion of Mr. Syme's, worth publishing, perhaps you will do me the favour to insert it in your Gazette.

I am, Sir,
Your very obedient Servant,
David Jamison, M.D.

Dislocation into the Ischiatic Foramen.

William M'Kay, 14 years of age, but having the appearance of being three or four years older from his size and muscular development, was admitted to the hospital on the 28th December, 1854. On the 19th December, nine days before his admission, he had been driving a horse and cart, the horse ran away, the cart was upset, and fell on him, injuring him severely. His left hip and back were most hurt. Three medical practitioners saw him soon after, but owing, I suppose, to the swelling and obscurity of the symptoms, did not discover the character of the accident to the hip. On examining him, I found his left leg about an inch shorter than the other; the trochanter was decidedly behind its usual position; the limb could be moved about considerably, but with great pain; the foot was *slightly* inverted; the symptom which Mr. Syme says is diagnostic of dislocation into the ischiatic notch was present; the lumbar vertebræ *were drawn forward*, the boy could not lie or stand straight; on placing and supporting him on his right leg, and keeping his body well up, the strange abnormal forward position of the lower part of the spine was very remarkable. Though at the time I had not the advantage of knowing Mr. Syme's opinion, and though the case was sent to me as a case of fracture of the femur, I feel some gratification in stating that I at once pronounced it a case of luxation into the ischiatic notch.

I sickened my patient with tartar emetic, and applied the pulleys nearly in the same way as for dislocation on the dorsum of the ilium; after some little difficulty the bone was reduced with a shock. At the time of its reduction I had my hand on the trochanter major, and felt quite distinctly what I deem worth noting, and worth looking for perhaps in fit cases, as it is a distinct matter from the shock or snap. As my hand pressed on and followed the bone, a slight double slide *from* the hand towards the mesial line, and a double stop and tap at the terminus of each slide; the shock or snap of reduction accompanied, visibly and audibly, this double slip from my hand. Is it not likely that this double slide may be felt where there is no shock or snap accompanying reduction?

My patient, M'Kay, was able to walk with a crutch in three days, and left the hospital on 27th January, 1855, believing himself then able to resume his occupation of farm labourer. My reason for thinking the case worth publishing is the presence of Syme's symptom.

Remarks on the Use of Blancard's Pills of Iodide of Iron.

BY SAMUEL WILMOT, M.D.,

SURGEON TO STEEVENS'S HOSPITAL.

Few medicines enjoy a more undisputed claim to a high rank among therapeutic agents than the iodide of iron; since its introduction into practice, its efficacy has been proved to the satisfaction of the profession.

In scrofula, in secondary and tertiary syphilis, in lupoid affections, and even in many states of the system unconnected with specific diseases, this remedy tells in the most decisive manner. A good form for its administration, however, has hitherto been a desideratum. The syrup, the preparation in ordinary use, is objectionable in many respects; its sweetness renders it disagreeable to some, it leaves an unpleasant taste on the mouth, it blackens the teeth and gums, and is apt to derange the stomach. These objections certainly cannot be urged against the pills prepared by M. Blancard with so much pharmaceutical skill. I have lately prescribed these pills in cases of the above named diseases, both in hospital and private practice, and have found them, as a general rule, the best form of administering the iodide of iron, which has, up to the present, been introduced.

I have not employed Blancard's pills to a sufficient extent as yet, to justify me in giving a positive opinion on the following point, but it has struck me that the mode in which the iodide of iron is combined in them enhances greatly the therapeutic efficacy of that medicine, since I have seldom found it necessary to order more than one pill for a dose, though each contains not more than three-fourths of a grain of the iodide of iron; whereas, in prescribing the syrup, every practitioner must have observed that in order to procure the full effect of the medicine, particularly in obstinate syphilitic cases, it is often necessary to increase its dose to an extent which deranges the stomach and demands its omission.

If this conjecture be confirmed by further experience, the advantages of the preparation here alluded to cannot fail to be universally acknowledged.

DISEASES OF THE SKIN.

From the French of M. Maurice Chausit.

BY J. K. BARTON, A.B., M.B., T.C.D., &c.

(*Continued from page* 91.)

M. Cazenave's first group of skin diseases is characterized by an inflammation of some or all the tissues of the skin, evinced by its usual symptoms, viz., heat, redness, swelling, and pain, and giving rise to its accustomed products, viz., lymphy, purulent, or serous secretion.

As seen in the table, the group of inflammations is divided into four classes; the first of these are, non-specific eruptions, which may exist either in an acute or chronic form. Under this head are ranged ten diseases, viz., erythema, erysipelas, urticaria, strophulus, herpes, eczema, pemphigus, impetigo, ecthyma, and sycosis.

These I purpose to examine in order, dwelling particularly upon whatever is new, or seems practically important and useful.

Article 1.—*Erythema.*

Definition.—Erythema is a non-specific inflammation of the skin, either acute or chronic, characterized by superficial red patches of variable form and extent, more or less circumscribed, which always disappear upon pressure.

Simple erythema generally developes itself without any general disturbance of the system, or such as hardly attracts the attention of the patient. It manifests itself by the appearance of red patches, generally diffused, sometimes circumscribed, of variable extent, rarely less than the palm of the hand; most frequently they are confined to a peculiar locality; sometimes they cover the whole of a limb, but rarely the entire body. Should the eruption be very extensive, the general disturbance will be proportional; locally, there is a feeling of heat and tension, nothing worthy of the name of pain. At the end of four or five days, sometimes after some hours, the spots begin to grow pale; if circumscribed, they become diffuse, and the disease disappears, leaving in some cases a slight desquamation, in others no trace whatever.

Besides the simple form, there are two varieties of erythema which merit especial notice; these are the *papular and the nodose or knotty* (erythema papulatum and nodosum of Willan).

In the *papular erythema* the spots are smaller and much more circumscribed than in the simple form of the disease; they are not generally larger than a threepenny piece, with distinctly defined edges, closely resembling papulæ, but when the finger is passed over them, no prominence is felt, in some cases a slight raising of the cuticle does take place, and then the diagnosis will be rendered obscure, but as a general rule, there is no prominence whatever of these spots above the surrounding skin.

Papular erythema, presents itself usually on the neck, chest, or arms, frequently on the back of the hands, in which situation it pursues a chronic course, and being accompanied with considerable swelling, has been named by Willan, erythema tuberculatum.

Nodose or knotty erythema is accompanied by much greater general disturbance of the system than is the last form; the eruption appears in the shape of oval spots, about the size of a shilling, of a vivid red colour, circumscribed, and presenting in the centre a decided raising of the skin; the finger passed over these spots feels a kind of nodosity. This swelling rapidly increases, and soon all the spots are converted into tumours, which appear to engage the whole tissue of the skin, in which they are as it were imbedded; the eruption now assumes a remarkable colour, viz., a deep obscure red, which disappears but imperfectly under the pressure of the finger. These tumours increase in size, sometimes becoming as large as a hen's egg. The slightest pressure causes pain; upon examination, they have a hard, resisting, knotty feel; sometimes, especially when the eruption is on the decline, they give a feeling of fluctuation, which might give rise to the idea, that the inflammation had ended in the formation of matter, which experience proves really never takes place.

Nodose erythema, which is certainly a more serious malady than the papular variety, generally lasts from ten to twelve days, rarely more than a fortnight; it is sometimes met in a chronic form.

Causes. — Erythema is generally developed under the influence of some external cause, such as the direct action of cold, exposure to a very hot fire, or the contact of irritating secretions; it usually occurs in persons of a fine skin and lymphatic temperament, and in such, it may arise merely from the friction of two surfaces together. In certain cases it is symptomatic of some general disturbance of the economy; thus, in children it coincides with the period of dentition, and in young girls it appears at the period of commencing menstruation; it is occasioned sometimes by the ingestion of certain kinds of food.

The eruption of erythema may appear on any part of the body, but very seldom on the whole of it, and this want of universality, and at the same time want of general symptoms, will suffice clearly to distinguish it from either measles or scarlatina, with which it might otherwise be confounded. The phenomena of congestion seems to indicate that its anatomical seat is in the capillary network of the skin, which is superficially inflamed.

Treatment.—When erythema is produced by any external or direct cause, the removing of this, it is plain, must be the first step in treating the disease; when this is done, in the majority of cases, some laxative medicine and an abstemious *regime* will complete the cure. But when erythema is developed under the influence of some general disturbance of the system, it is to the relief of this our treatment must be directed; thus, blood-letting in some form will be useful, when the menstrual function is deranged.

When the knotty erythema has its seat in the lower limbs, absolute rest and the antiphlogistic line of treatment must be enforced.

Topical remedies, either emollient or astringent, will be found in all cases quite useless.

Article 2.—*Erysipelas.*

Definition.—Erysipelas is a non-contagious inflammation of the skin, and the areolar tissue beneath it, to a variable extent, characterized by a circumscribed redness, accompanied with heat and pain more or less acute, a tumefaction sensible to the touch, and a tense shining state of the cuticle. M. Cazenave divides all cases of erysipelas into three distinct classes, under which all the different varieties may be arranged—viz.:—1st. Simple erysipelas, when the inflammation engages the skin only; 2nd. Phlegmonous erysipelas, when both the skin and the areolar tissue are involved; and 3rd. Gangrenous erysipelas, when the inflammation is essentially of a sloughy character, whatever may be the tissue affected or the depth of the disease.

1st. *Simple Erysipelas.*—Symptoms of general disturbance, viz., a feeling of weariness, followed by headache, nausea, and shivering, almost always precede the appearance of erysipelas, the intensity of these precursory symptoms being proportional to the extent of the coming disease. A painful enlargement of the lymphatics in the neighbourhood where the inflammation is about to appear, described first by Borsieri, has been dwelt upon by MM. Chomel and Blache, and is regarded by them as quite peculiar to erysipelas.

The integument attacked by erysipelas presents the following phenomena:—First, a sensation to the patient of dryness, heat, and burning; then, on the second or third day from the commencement of general symptoms, a patch of redness appears, clearly declaring the disease; this rapidly extends its border, differing in colour from a light red to deep violet; it disappears momentarily upon pressure; the swelling accompanying it is very perceptible to the touch, and wherever the cellular tissue is loose, becomes very apparent. As these local phenomena develope themselves, the general disturbance of the system increases in severity. Towards the fifth or sixth day, in a favourable case of simple erysipelas, the redness begins to grow pale, the swelling diminishes, and the tense and shining integument becomes wrinkled. Frequently, however, it is much more irregular in its course; sometimes extending rapidly from its original seat to all the neighbouring parts, thus occasionally engaging the whole surface of the body at the same time; or before going through all its stages in its original seat, it may appear in quite a different part, thus pursuing an *erratic* course for some days; or again sometimes it *periodically* disappears and returns.

Phlegmonous Erysipelas.—Erysipelas is so called when it engages both the skin and areola tissue to a greater or less extent. The general disturbance is great, differing in intensity according to the depth and extent of the inflammation; the local symptoms are more marked; the redness is deeper; it is effaced but incompletely by pressure; acute pain is given even by a superficial examination of the part. Resolution may take place towards the fifth or sixth day, but generally the disease continues to progress; the pain becomes pulsative; a sensation of weight is complained of in the part; the redness declines, the swelling increases, and suppuration is established. When the inflammation involves the aponeurotic structures, alarming symptoms present themselves; the disease advances rapidly, and is serious, not only from the general disturbance, but from the local mischief it causes; spots of deeper colour appear over the erysipelatous surface; the skin loses its sensibility; vesicles appear; an eschar forms, which, when separated, leaves large ulcerations, which slowly cicatrize. But frequently the event will not be so happy. Sometimes the fever persists; gastro-intestinal inflammation appears, the prostration becoming extreme, and the patient sinks, often an uncontrollable diarrhœa being the immediate cause of death.

Gangrenous Erysipelas.—By this is meant only erysipelas essentially, and from its commencement, gangrenous, not gangrene resulting from excess of inflammation, as we see occur in the phlegmonous form. We meet with it in old persons, and such as are prematurely old, either from excess or privation; the puerperal state seems to constitute a condition favourable to its development.

Erysipelas presents, according to the seat it occupies, several varieties which differ in their symptoms, and frequently in their termination; thus erysipelas of the head and face, before it is recognized, may give rise to all the symptoms of meningitis, which, however, will pass off completely as the disease pursues its regular course. Erysipelas in new-born infants generally appears in the umbilical region, and is always a serious disease; not unfrequently it is followed by suppuration, gangrene of the genital organs, and death.

Causes.—The causes of erysipelas are often obscure; the following general statements may, however, be made as the result of experience:—1st. It is more frequent in young and middle-aged persons than in the old. 2nd. Women are more subject to it than men. 3rd. It is more frequent in spring and autumn than in the other seasons of the year. 4th. It attacks all kinds of constitutions, but the individual temperament seems to influence the form and character of the disease.

It appears sometimes to follow the suppression of some accustomed evacuation, and frequently immediately follows a wound or laceration of the skin; but these last must be looked upon rather as the secondary or existing, than the primary or predisposing causes.

Anatomical Seat.—Several different opinions have been held with regard to the tissue chiefly engaged in erysipelas; some maintaining that the lymphatics were inflamed, others that the ultimate venous twigs were the vessels chiefly engaged. Amongst the supporters of this last are Copland and Cruveilhier. More recent researches, however, upon the morbid anatomy of erysipelas establish that this inflammation engages in different degrees the skin, the ultimate venous twigs, and the lymphatics. The skin is usually found of a greyish colour, softer than natural, the cuticle very easily raised, and the whole showing a marked tendency to pass into a state of decomposition.

Both the veins and lymphatics have been found either simply red, or presenting traces of greater inflammation, and containing pus in their interior.

Treatment.—The treatment required for erysipelas differs most materially according to its form. In a case of simple erysipelas we must remember that it is an inflammation of but slight importance in itself, and almost always pursuing a regular course, to a favourable termination. Our chief care, then, will be not to interfere, and to watch carefully for any complication which may arise.

In the phlegmonous form of the disease, however, early and energetic treatment is demanded: blood-letting, general or local, according to the state of the patient. Mercurial ointment, smeared over the surface, is much recommended by some. Others prefer painting it with a strong solution of nitrate of silver. These may be employed with advantage in the early stage; but if the inflammation ends either in suppuration or sloughing of the areolar tissue, then free incisions must be practised, and the best results generally follow such treatment, if done decidedly and in proper time.

In gangrenous erysipelas, such means must be used as the peculiar state of the patient demands; these generally include a substantial, nourishing diet, a tonic and stimulant treatment general, and dressings calculated to restore the energy of the living, and thus cause the separation of the dead parts.

PATHOLOGICAL SOCIETY MEETINGS.

February 24th, 1855.

THE PRESIDENT, MR. ADAMS, IN THE CHAIR.

Acute Softening of Cerebrum.

PROFESSOR BANKS submitted the following case:—A boy, aged 17, was admitted into the Hardwicke Hospital on Tuesday last. He had complained for a week previously of pain in his head and cramps in the limbs, but the Sunday before his admission he walked to the Park, and returned home in the afternoon. It was on the evening of that day, while playing on a musical instrument, he was alarmed by his fingers suddenly becoming powerless. He remained in bed Monday and Tuesday, and on the latter day he was brought to hospital, and presented the following symptoms:—He complained of numbness of the right arm, and appeared irritable and impatient, moaning, and at times very drowsy. The night after his admission he slept well, but the following day he complained of his head; the muscles of the neck were stiff, the head was drawn back, and the rigidity was such as to prevent him from raising his head. At intervals there were twitchings of the muscles; retention of urine at first, and subsequently incontinence. On the third day he had profuse sweating, which was followed by coldness of the extremities; and yesterday morning he was seized with a fit, in the course of which he became quite black, his features were convulsed, vomiting and purging came on after the fit terminated, the latter continuing to the close of life. During the fit the pupils were alternately contracted and dilated, but answered to the stimulus of light. He appeared now to be intelligent, but required to be spoken to sharply before he gave evidence of attention. Subsequently to this his respiration became very rapid, and there was nothing in the chest to account for its irregularity. At eleven o'clock last night, he got another fit similar to the former, the eyes were fixed, and the pupils dilated and insensible to light at first, but after a time they slowly responded to the stimulus. With these symptoms there was also diminished sensibility of the surface of the body. He died on the fourth day after entering the hospital.

Autopsy.—The surface of the brain was intensely vascular, the arachnoid membrane appeared to be free from disease, but the pia mater was intensely red, looking like scarlet cloth. There were also, in some places, traces of the effects of inflammation, resembling the marks left by nitrate of silver, and the surface of the brain was so soft in some parts as to give way on the slightest pressure. The upper part of the spinal marrow presented an intensely vascular appearance. There was no softening in the interior of the brain, but on opening the dura mater of the cord, serum flowed out in much greater quantity than is usually met with.

This case presented, in some respects, a great similarity in character to that form of cerebro-spinal meningitis which occurred epidemically in this country in '46 and '47, and of which an admirable report has been given in the *Quarterly Journal*, by Doctor Mayne.

Doctor Banks proceeded to contrast the case under consideration with one of genuine cerebro-spinal meningitis which had lately been under his observation, and the details of which are given at length in the HOSPITAL GAZETTE.*

Fatty Degeneration of the Heart.

DR. M'DOWEL detailed the following case:—A young girl, 16 or 17 years of age, was admitted into the Hardwicke Hospital, in the month of December, 1854, labouring under fever. There was no eruption on the skin, yet extreme prostration marked the course of the disease. The patient, however, had become almost convalescent when she was suddenly attacked with suffocative catarrh. The symptoms soon became very urgent. The breathing was hurried, with frequent cough and copious thin frothy expectoration; the face was remarkably pale. The treatment consisted in extensive counter-irritation, and the free exhibition of stimulants. The disease, however, ran its course with great rapidity; the breathing became more hurried; mucus accumulated in the tubes, and death ensued twenty-four hours from the commencement of the pulmonary affection.

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* See page 83.

There were several circumstances connected with this case which were peculiar, viz.:—The occurrence of suffocative catarrh at so early an age; the rapidity with which it proved fatal in a person who had not previously suffered from any chest affection, and the failure of stimulants, though given in large quantities, to produce any impression on the vital powers. For an explanation of these circumstances, the *post mortem* examination was anxiously looked for.

Post Mortem Examination.—The lungs were large and naturally crepitant; the tubes were filled with frothy mucus as high as the trachea; the bronchial mucous membrane was slightly more vascular than natural, but there were no satisfactory evidences of acute inflammation having existed; the heart was extremely small; externally it was thickly covered with fat, especially its right chambers; on the right side the muscular tissue was in a great degree replaced by fat; in some spots the muscular tissue had entirely disappeared, whilst in no part did it exceed a few lines in thickness.

The right auricle was reduced to a mere membranous cavity. In the right ventricle some of the carneæ columnæ were transformed into fat; on the left side the cavities were of their normal thickness, but the fibres were paler than natural. Fatty degeneration was apparently limited to the tissue of the right chambers.

Microscopic examination by Mr. Richardson subsequently showed that the degeneration affected the fibres of the left cavities also, but in a less degree than those of the right side.

The liver and kidneys were healthy.

Dr. M'Dowel made some observations on the pathology of this disease, and in conclusion said, that in the preceding case the great extent of degeneration on the right side of the heart explained the rapidity with which pulmonary congestion had proved fatal, and the inutility of the treatment, which, under other circumstances, is sometimes successful. Dr. M'Dowel likewise directed attention to the rarity of this disease at so early an age.

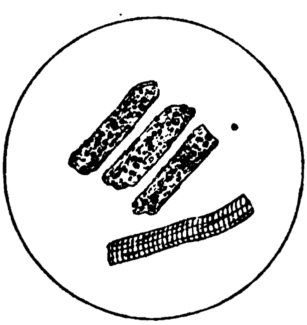
In the Transactions of the London Pathological Society (1854) Dr. Bristowe mentions a case of fatty degeneration occurring in a boy 11 years of age.*

Fatty Degeneration of Heart and of Placenta.

Mr. B. Wills Richardson said he had carefully examined the heart of the girl, whose case Dr. M'Dowel had just related, and found that the right auricle and right and left ventricles presented admirable specimens of true fatty degeneration; the transverse striæ had completely disappeared, and the sarcolemma seemed to be nearly filled with oil particles.

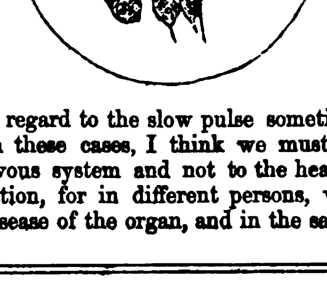
Fig. 1 is a copy of the microscopic drawing which I made at the time of the examination. It represents degenerated fibres from the right auricle, in which, judging from the portions I dissected, the disease seemed most advanced. Beneath the three degenerated fibres is depicted a healthy fibre, which forms a striking contrast with the others.

Fig. 1.



Some time since I examined the heart of an old man who laboured under fatty degeneration of the organ. Fig. 2 shows the state of the fibres from the left ventricle. Although in his case the disease was as general as in Dr. M'Dowel's, yet it was not so far advanced. In the greater portion of the fibres, some of the transverse striæ were still visible, as may be seen on examination of the accompanying illustration.

Fig. 2.



With regard to the slow pulse sometimes met with in these cases, I think we must look to the nervous system and not to the heart for its explanation, for in different persons, with this same disease of the organ, and in the same stage of the disease, the pulse varies from extreme rapidity to remarkable slowness.

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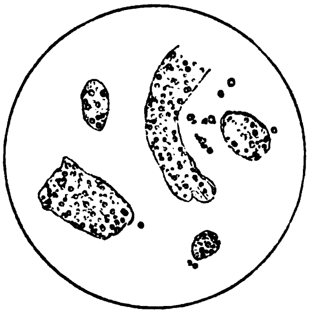
* Vol. v. p. 87.

In connexion with the present subject, I beg to draw the attention of the society to an example of fatty degeneration of the minute vessels of a placenta, which condition it is more than probable was the origin of the great number of apoplectic clots which existed in different parts of the mass. I am indebted to Dr. M'Clintock, the Master of the Lying-in Hospital, for the particulars of the case, as well as for the portion of the placenta which I examined. A woman was prematurely delivered of a putrid fœtus in the hospital; the placenta was found to be rather below the normal size at this period of gestation; its surface was wrinkled, and here and there yellowish indurated tumours could be felt. On laying it open, in addition to a few yellowish fatty-looking tubercles, it was found to contain a considerable number of apoplectic clots, two of which were soft, semi-fluid, and recent, but the remainder were of older date, varying in consistency, and presenting different stages of alteration highly illustrative of the changes blood undergoes after effusion. The minute vessels of the portion of this placenta which I examined microscopically, were in an advanced state of fatty degeneration, closely resembling the illustration which Dr. Barnes of London has given in his original memoir on fatty degeneration of the placenta. Fig. 3 shows the condition of these vessels, which seems to be identical with a similar state of the minute vessels of the brain, first described, I believe, by Mr. Paget, and which is a frequent precursor of cerebral hemorrhage; indeed, I am inclined to the opinion, that a considerable number of sanguineous cerebral effusions, instead of depending upon determination of blood to the head, strictly so called, will be found to be the result of the rupture of the brittle vessels.* It is exceedingly probable, reasoning from analogy, that the apoplectic clots in the placenta above alluded to were also the consequence of the rupture of its fragile and degenerated vessels. In this case some of the cells of the decidua were also loaded with oil globules, so that the maternal portion of the placenta was not free from disease. It is evident, from the appearances of the apoplectic effusions, that they must have occurred at different periods, and according as they increased in number, have encroached upon the structure of the after birth, and have interfered so materially with its functions as to occasion the death of the fœtus, and its premature expulsion from the uterus.

Fig. 3.



Stricture of the Urethra and Urinary Abscess, with Purulent Deposits in the Kidneys.

Mr. Hamilton said,—The specimen which I bring before the Society illustrates the injurious and fatal consequences which result from neglected stricture. In certain constitutions these effects occur very rapidly. The patient now under consideration was evidently one who resisted badly the progress of disease, the fatal termination having ensued a comparatively short period after the first commencement of the stricture. A tall, thin young man, of the name of Lalor, was admitted into the Richmond Hospital November, 1854. When he came to the hospital for admission I was struck by his aspect—that of one labouring under mortal disease. He had stricture of the urethra of three years' standing, after gonorrhœa. For the first year no instrument was passed: at the end of that time he came under my care for a short period. The stricture was very irritable; but he derived much benefit from the introduction of instruments. He left the hospital too soon, and I never saw him again till now. He had latterly got much worse, the urine constantly dribbling away, with frequent rigors, and great prostration of strength, so that he could scarcely stand.

There was a tumour—evidently a urinary abscess—connected with the under part of the urethra, in the centre of the scrotum, between the two testicles. It was about the size of small apple, soft and fluctuating, with the feel of containing a thin fluid. When this was pressed urine flowed from the orifice of the urethra. A gum elastic catheter was stopped by a hard stricture two inches down, just anterior to the swelling. A small gum elastic bougie was then passed, and the point well pressed in the orifice of the stricture. It was left in a minute or two, after which No. 4 catheter was passed with some force through the stricture into the dilatation behind it. Turbid urine, with flakes of lymph, flowed out through the catheter, and the tumour became flat and flaccid. Next day the abscess having refilled, was emptied in the same way. I then with some difficulty passed in No. 4 silver catheter into the bladder, and drew off a pint, at least, of urine, faintly acid, and containing pure pus. I could feel through the flaccid tumour the silver instrument in the urethra, and that there was an oblong hole at the lower part of the urethra communicating with that passage by so free an opening that the urine must not only have filled it, but washed out the pus.

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* According to Mr. Paget's investigations, "the arteries of 1-300th of an inch in diameter are the most liable to this disease, but it may coexist in the veins of the same or of less size." There are exceptions, however, to this rule, for he has found "vessels of from 1-2000th to 1-3000th of an inch in diameter affected." Dr. Jenner has discovered that the appearances of oil particles may be "imitated by equally minute particles deposited in the same manner, but which are shown to be calcareous by their solubility in hydrochloric acid."—*Paget's Lectures on Pathology*, vol. i., p. 139-141.

He gradually got worse. The pure pus which came through the catheter from the bladder made me apprehend disease of the kidney, though he did not complain of pain in the loins—his chief attention being directed to the urethra. He was, however, greatly emaciated, complained of constant thirst, was very languid, and depressed to the greatest degree. Pulse rapid and small; obstinate bowel complaint. At length, after having been in the hospital a fortnight, he died, nothing having been done to the urinary abscess. He never could summon courage to let it be opened, nor did I insist on it, as no good could be expected in a creature so wasted by other disease.

The *post mortem* examination proved the correctness of the opinion that there was an abscess in the kidney. A stricture was found two-and-a-half inches from the orifice of the urethra; before it were two small ulcers, the size of split peas. The stricture was very narrow; behind it was the opening leading into the abscess. It was a large opening, and presented the appearance of ulceration at its margin. The interior of the abscess was even, but not smooth; the surface flaky, from deposit of greenish lymph; it contained a small quantity of urine and pus. From the edge of the abscess to the bladder the urethra was dilated; no appearance of stricture anywhere; of a red purplish colour, from congestion. The bladder was much diseased, and full of pus, there being three or four ounces with a little urine; the mucous membrane of a modena colour; the columnæ very well marked, and the walls half an inch thick; a little less than natural in size. The kidneys very much diseased, of large size, and deep crimson colour; full of small abscesses, the size of peas, in the cortical substance of the kidney, some appearing larger when a section was made. The pus in them thick and concrete. The pelvis and calyces dark purple, from congestive inflammation. There were a few tubercles in the lungs.

SELECTIONS FROM BRITISH AND FOREIGN JOURNALS, &c., &c.

Case of Anæmic Palpitation.—Enlargement of the Thyroid Gland and Eyeballs. By James Begbie, M.D., President of the Royal College of Physicians, Edinburgh.—J. K., aged 32, by occupation a gentleman's servant, many years ago had a fall from horseback, by which he sustained a severe wound on the occiput, from which a profuse and continued hæmorrhage took place. He has never been quite well since that occurrence. In the beginning of 1845 he suffered from bilious fever, and made a slow and imperfect recovery. In August, 1851, had an attack of jaundice, which continued more or less for a whole year; and during its progress the symptoms which first attracted attention in connexion with the present history developed themselves. For more than a twelvemonth he has been subject to palpitation, breathlessness, and giddiness. These symptoms were soon followed by enlargement of the thyroid gland, and by increased prominence and distention of the eye-balls, so as to give him a remarkable appearance of staring, which was noticed by all his friends.

In the spring of 1853 he first came under my observation. He was a man of middle size, and well-formed. His countenance was pallid and sickly; but under excitement, either mental or bodily, his face quickly flushed, and his manner became nervous and embarrassed. At all times, but especially under excitement, the action of the heart was forcible and rapid, and this action was communicated to the vessels of the neck and head. The eye-balls were enlarged and prominent, presenting the appearance of great distention. The thyroid gland was also much enlarged throughout its whole body, varying in size according to the force of the heart's action. This enlargement was accompanied by a strong pulsation over the tumour, and in the vessels of the neck; and a peculiar thrill was felt, and a loud murmur heard, over the whole extent of the gland. The action of the heart was violent and jerking; and a loud bellows murmur attended the first sound, and was heard most distinctly over the region of the aortic valves. In a state of quiet and rest these symptoms became moderated, and the patient was able to continue his domestic service, in the enjoyment of comparative health. He was directed to take persistently for months the milder preparations of iron, and to use a diet chiefly of animal food. Under this plan he improved in health, and all his more urgent symptoms subsided by degrees. In the autumn of 1853, he went to England, and continued, I understand, to improve in health; but I lost sight of him at this time. Early in the spring of 1854, he had engaged to accompany a distinguished officer to the Crimea, as his body-servant. Before the time arrived, however, when he was to have entered on his duties, he was, after exposure to cold and fatigue, seized with inflammation of the chest, and obliged to relinquish the undertaking. His illness was severe and continued, and he never recovered from it. It appears to have aggravated greatly the peculiar symptoms under which he had so long laboured, and complicated the aspect of his case. He was able to return to Scotland, however, and in March, 1854, he again, after an interval of several months, came under my notice. At this time he had enlargement of the liver, with jaundice, and the signs of organic disease of the heart, accompanied with general dropsy. His eyes were still prominent, and the thyroid gland enlarged, but neither of these now maintained the striking character which they possessed previously to his leaving Scotland. No remedy was of any avail, and he sank on the 28th of March, worn out with the sufferings of complicated disease in the thorax and abdomen. The body was opened on the 30th by Mr. Johnston, in presence of Drs. W. T. Gairdner and Warburton Begbie, and myself.

Sectio Cadaveris—March 30, 4 P.M.—Body of a moderately stout and middle-sized man. The linens in which the body was shrouded were in many parts (as the neck, axilla, scrotum, and legs), quite soaked with serous fluid exuded from the body. The cuticle was in many parts loose and easily detached from the *cutis vera*, and in every organ of the body examined, signs of decomposition were generally met with—frequently so marked as to obscure the proper pathological conditions.

The subcutaneous tissue, and indeed the cellular tissue generally, contained very little fat, and was in every part more or less infiltrated with serum.

On opening the thorax, the *pericardium* was found of large size, and overlapped, at its sides only, by the margins of the lungs. It contained about *six ounces* of a transparent yellow-coloured fluid. Upon the anterior surface of the heart—near to its base—a "milky spot" was observed about the size of a florin-piece, and another upon the opposite surface of the pericardium.

All the cavities of the *heart* were filled with dark-coloured blood in a more than usually fluid condition; one well-formed decolorized clot was found in the right ventricle. The heart was large (might have weighed 16 oz.), soft, and flaccid. All its chambers, but more especially the *ventricles*, were considerably dilated; the tricuspid orifice admitted *four* fingers, the mitral *three*. The tricuspid and mitral valves were large, but otherwise normal; the sigmoid valves were also normal. The *vena cava* inferior was unusually large; and the aorta was small when compared with the size of the pulmonary artery. The endocardium and inner surface of the aorta were stained of a deep red colour.

Both pleuræ contained turbid fluid of a dark red colour, computed at about eight or ten ounces in each. The posterior surface of the upper lobe of the *right* lung was firmly adherent to the costal pleura by strong short bands of lymph. The lower lobe of this lung was crepitant, and infiltrated with bloody serum; the posterior part of the upper lobe was condensed, non-crepitant, and friable, as if hepatized, but the advanced state of decomposition in which it was prevented a decided opinion being formed concerning it. The left lung was crepitant, with the exception of its posterior part; and from the surface of a section a considerable quantity of bloody serosity was readily expressed.

The sterno-hyoid and sterno-thyroid muscles were much thinner and broader than natural, from being stretched over the thyroid body, which were of large size. The external jugular vein was normal; the internal jugulars were large—the left one, when slit open, measured an inch and a half across at a level with the cricoid cartilage. The thyroid body was of large size, but was not weighed; its weight may, however, be computed at being four or five times greater than natural. Each lateral lobe measured an inch and a half in breadth, and was of a corresponding thickness. This great increase in size was not partial but general, and although the *isthmus* was comparatively larger than the lateral lobes, there was complete symmetry of both sides. It was of a dusky-red colour, smooth, and well-defined, and slightly irregular on its anterior surface, but still retained the natural convex and semi-lunar form of the organ when in a state of health.

The peritoneum contained about a pint and a half, or two pints, of a clear fluid, tinged of a bright yellow. The *spleen* was enlarged in all its diameters, and was computed to weigh about twenty ounces. It was of very firm consistence, and on section presented the trabeculæ well-marked, and also the Malpighian bodies, which were of an opaque yellowish white appearance. The *kidneys* were both very large and very soft. The cortical was to the medullary substance, relatively, increased in amount, and the great size of both organs seemed to arise from this circumstance; otherwise their actual pathological condition could not be ascertained on account of the advanced state of decomposition which they were in. The *liver* was certainly not enlarged, perhaps rather small; its surface was somewhat irregular, slightly and superficially fissured at points; no rounded nodules, however (as of cirrhosis), could be observed. On section the tissue was (considering the decomposed state of all the organs) rather hard and dense, and seemed partially atrophied; its colour was deep-orange, and in some places there was an approach to "nutmeg" congestion.

This case presents a well-marked example of the disease first described by Dr. Graves of Dublin, and afterwards noticed by Sir Henry Marsh, Dr. Stokes, and other Irish physicians; and whose true pathological character was, I believe, first pointed out by me in a paper read to the Medico-Chirurgical Society of Edinburgh in January, 1849, and subsequently published in the Monthly Journal of Medical Science. The affection has since been illustrated by Romberg and Henoch, and other German physicians, and has attracted the notice of some of our best writers on diseases of the eye. The history is interesting, as having occurred in a male, the cases on record, with few exceptions, having been seen in females. It is more particularly interesting, as affording an opportunity of examining the morbid appearances after death, the only record of which that has yet appeared being that communicated to the Pathological Society of Dublin by Sir H. Marsh, and by Basedow in Germany. In the case now related, as well as in that of a lady who had long laboured under this peculiar affection, and in whom it proved fatal also, by supervening pneumonia (the only instances which have occurred to myself of instituting *post-mortem* examinations), there exists a remarkable similarity in the chief morbid appearances with those described by Sir H. Marsh. These appearances chiefly consist in the very fluid state of the blood found in the heart and great vessels, in the dilatation of the cavities of the heart, and of the venous trunks, in the enlargement of the spleen and disease of the liver, and in serous effusion into the different cavities, the result of vascular obstruction.

Since the publication of the three cases related by me in 1849, I have, through the kindness of my professional brethren, seen many additional examples of this affection, a large proportion of which have gradually undergone a cure, while the remainder have benefited, or are now benefiting, by the use of iron, animal food, and fresh air. It is of great consequence to impress those suffering from this affection with the belief of its curable nature, and to urge upon them the persistent employment of the means of restoring the red particles of the impoverished blood, and improving the general health; for we have now examples before us to shew that the neglect of these rules must lead, from functional disorder of the heart, to dilatation of its cavities, and to the usual train of consequences resulting from such a morbid change.

The more extended our experience of the phenomena constituting this peculiar affection becomes, the more convinced shall we be that the point of departure from health is not in the heart itself, but in the impoverished condition of the blood, which, after a time, affects the heart and vessels functionally, and, by long continuance, involves them ultimately in fatal organic change.—*From Case Book of Edinburgh Medical and Surgical Journal.*

Treatment of Chorea.—We find in the *Bulletin Therapeutique* the following observations upon the treatment of chorea. After some remarks upon the various modes of treatment which have been adopted in this disease, the author says:—It is too often insisted upon, that chorea is always a mild affection, which, if left to itself, will recover in due time. We find, from the frequent examples of this disease which occur in the various children's hospitals, that such is not really the case.

In that of Paris, there is not a year passes in which cases of great severity are not recorded, ending in the death of the little patient; the fatal termination coming on so rapidly sometimes, as to afford no opportunity for employing the usual remedies.

The narcotic line of treatment furnishes for obstinate cases of chorea the greatest advantages; but opium, the best of our agents in this class, must be used in such large doses, that the greater number of physicians do not dare prescribe them. M. Trousseau does not hesitate to prescribe opium to the amount of fifteen grains in the day. He says: "We prescribe half a grain every hour, until the convulsive movements are calmed." We do not hesitate to place the calmative line of treatment decidedly before the tetanic, and the greater number of practical physicians, at the head of whom we would place the physicians of the *Enfans Malades*, are of the same opinion. We have seen children attacked with very intense chorea, who take from three to four grains of extract of opium in the twenty-four hours. But when considerable doses of this narcotic *par excellence* fail to subdue the violence of the movements, we think with M. Géry that the inhalation of chloroform is the means which will most rapidly and surely fulfil the indication.

The first observation which M. Géry gives in evidence of the usefulness of the anæsthetic agent, is that of a boy, fourteen years of age, who, without any taint of constitution, and only fifteen days from the country, was attacked with such a severe form of chorea, that upon the evening of the fifth day the following description is given of his state:—

The movements affected both limbs alike with such violence that the legs, which were firmly bound together, were separated by a vigorous effort, breaking the cords which tied them. The face was deeply congested, the eyes were injected, and two other patients were unable to keep him in bed, although tied down; at last, the child, with extraordinary strength, suddenly broke through all restraint, leaped from his bed, overthrowing a wardmaid who attempted to hold him, and threw himself upon the bed of another little patient; three strong men, called in haste, had much trouble to catch and restrain him, and when we arrived (says M. Géry) we found the patient lying naked in his bed, the movements being of such intensity as to raise him from the bed, and *faire pirouttèr* the men who held him. Chloroform was given repeatedly with good effect at the time, but when its influence passed off, all the bad symptoms returned, and the little patient died upon the evening of the ninth day of his illness.

The great fact which demands observation in this case, says M. Géry, is the intensity of the movements. In their learned treatise upon the diseases of children, MM. Rilliet et Barthez say, that in those cases of chorea which end fatally, we find the movements acquire progressively an extreme violence; in the way of prognosis, then, the intensity of the movements demands consideration. In the worst cases these movements have always been most exaggerated; it is to combat these that we advise the inhalation of the vapour of chloroform.

The following precautions should, however, be insisted upon. In children it will be necessary to take care that the stomach is empty, for when this is the case neither nausea nor vomiting will occur, which fatigues and distresses the little patient.

It is necessary in all cases constantly to watch the pulse and the respiration. As a general rule, the pulse, which is accelerated while the inhalation is going on, falls during the duration of the sleep, remounting again whenever this ceases. Sometimes the pulse is irregular both in frequency and force. However, there should always be one examining the radial artery, on the alert for any failure of the circulation. The same precautions should be taken with regard to the respiration, which, in general, at the commencement, is much disturbed by the movements of the child, but become quiet during the sleep.—*Bulletin Therapeutique.*

Iodine Injection in Pleuritic Effusion. By Dr. Atlee.—Dr. Atlee relates the case of a gentleman (age not given), from whose side nine pints of pus were discharged on the 16th December, through a trocar passed into the left side of the chest between the seventh and eighth ribs, midway between the spine and the sternum. No further discharge took place until the 2nd of January, but the closed wound then re-opened, and from that time about a pint of pus continued to be discharged daily, with the effect, in spite of restoratives, of rapidly wasting the patient's strength. On February 2nd, ʒ½ of liq. iodin. c. (U. S. Disp.), diluted with ℥i. of tepid water, was thrown in without inducing any ill effect, no precaution against the admission of air being taken; and next day the amount of discharge was found diminished by one-half. Each day the strength of the injection was increased, and on the 7th February the iodine was used undiluted. The amount of matter discharged rapidly decreased, and by the end of February the flow had ceased, the patient daily recovering strength, and in a few weeks later being able to go to business. When seen three years later he was quite well, and had insured his life. On examination the left side of the chest was found measuring 2½ inches less round than the right. The respiration was normal, and the heart's action was audible in the natural locality.

During the discussion upon this paper, Dr. Bowditch related an interesting case which occurred in the person of a young woman, who, during a three months' treatment, had her chest tapped seven times. A steady improvement and a diminution in the size of the collection ensuing each time, and the intervals between the operations being gradually increased. During all this time pregnancy steadily advanced, and the fœtus was vigorous in its movements. At first a large trocar was employed, so that by leaving the canula *in situ* a fistulous opening might be produced; but it became displaced, and caused much more irritation than the small one employed on subsequent occasions. Dr. Bowditch observed that during the past three years he has operated with the small trocar seventy-seven times, and in no instance with ill effect. In all the cases when fluid was obtained relief followed; and in some the operation was the chief or sole cause of cure.—*Amer. Jour. of Med. Science.*

Case of Rupture of the Uterus and Gastrotomy—Recovery. By Dr. Mason.—This case occurred in a strong, healthy woman, pregnant with her sixth child. Her labour was going on slowly but naturally when, while passing a stool, she was seized with two dreadful pains, accompanied by the feeling of something having given way within. Although the pulse was little altered, and there was neither vomiting nor syncope, the total cessation of pains, the recession of the presenting part, and a sanguineous discharge gave rise to the fear of rupture; and on a closer examination the entire child was found to be external to the uterus. Her pulse continued firm, the countenance good, and skin natural; and, as she resolutely forbade any manual interference, a large dose of morphia was given her and she was left for the night.

Next morning (July 25), the same favourable conditions continued, and she now consented to gastrotomy, which was performed under the influence of æther. A large hydrocephalic child was found in the cavity of the abdomen. The rent in the uterus was enormous, but as soon as the placenta and coagula had been removed from its cavity, the organ contracted to the size of the fist. The blood, of which a large quantity was effused into the abdomen, was removed as far as possible, and the wound united by sutures. The strength was not much exhausted, and the pulse, although 120, was firm and equal. Grain doses of opium were given every hour with the effect of procuring sleep.

She went on very well, with the exception of occasional vomiting and an offensive vaginal discharge, until the 30th, when the pulse mounted up to 130 and 140, the body became covered with a clammy sweat, and altogether she seemed moribund. The mind of this remarkable woman nevertheless remained firm and composed, and she declared she was not dying, even when informed that such was the case. And, in fact, she rallied, and eventually recovered, though after similar vicissitudes recurring. By the 15th August she had come down stairs, and a month after the rupture had occurred she was engaged in washing.—*Amer. Jour. of Med. Science.*

Acute Œdema of the Scrotum.—Mr. Henry Smith related before the Medical Society of London a case of acute œdema of the scrotum which he had been called to lately, the symptoms of which had commenced previously by those attending ordinary swelled testicle, but, after a few hours, the characters of that affection rapidly merged into enormous inflammatory œdema of the whole of the scrotum. The case was very well marked. The swelling and inflammation did not extend either to the groins or to the perinæum; thus distinctive from infiltration of urine, for which at first it might have been mistaken. The gentleman in attendance had used antiphlogistic treatment, and had applied leeches to the scrotum; but so rapid was the disorganization of the part, that when free incisions were made by Mr. Smith, he found that sloughing of the cellular tissue had taken place. The result of this case showed the absolute necessity of free incisions; for all over the anterior and middle part of the scrotum, where the knife was carried, the sloughing was stopped; but at the posterior part, where the incisions could not be so well executed, rapid sloughing of both skin and cellular tissue took place to a great extent. The interest connected with these cases was great, insomuch as most prompt treatment was required; and, moreover, the idiopathic acute œdema of the scrotum is not very often met with. The late Mr. Liston had deemed it right to dedicate a paper to this simple affection, thus showing the importance he attributed to a right knowledge of its pathology and treatment.

Dr. Routh recollected acute œdema of the scrotum as almost an epidemic at University College Hospital in the practice of the late Mr. Liston. Cutting freely into the tumour was universally resorted to, but this did not invariably prevent sloughing, which, indeed, was common. The recovery in these cases was usually very slow, typhoid symptoms presenting themselves towards the close of the case. There was no difficulty of diagnosis in these cases: the skin of the scrotum was distended, like anasarca; red, like erysipelas.

Mr. Milton had seen two or three cases of the disease, which appeared to be closely related to, if not, erysipelas. He had not found incision more effective than the local application of evaporating lotions, &c.

Mr. Marson had seen many of these cases in the Small-pox Hospital, and regarded them as of an erysipelatous character. He had frequently employed incisions; but he could not say much in favour of that practice. The parts usually sloughed. In two cases the scrotum had sloughed entirely away; but the patients recovered, having good scroti afterwards. Ammonia, bark, and tonics were indicated. It was essentially an hospital disease.—*Lancet.*

Softening of the Brain from Fibrinous Plug lodged in Cerebral Artery.—A lady, of middle age, had for five years past been, more or less, an invalid. She had been seen by Dr. Robert Lee and Dr. Watson, and by the latter the diagnosis of valvular disease of the heart had been pronounced. Suddenly an attack of hemiplegia occurred; seven days after which death took place, the paralysis having been persistent. At the autopsy, besides an œdematous condition of the subarachnoid tissue, there was found extensive softening of the corpus striatum, on the side opposite to the one paralyzed. The arteries were then carefully inspected, and lodged in the middle cerebral of the same side, just at the point of its division, was a plug of fibrine, exactly resembling the warty growths often found on the valves of the heart. By this plug, which was perfectly loose, the vessel was distended so as to bulge externally, its calibre being quite filled. The heart was slightly enlarged, and on the curtains of the mitral valve, and also on those of the aortic semilunars, were numerous wart-like vegetations. There was a large mass of yellow fibrinous deposit in the spleen. The left femoral vein was quite obliterated, and converted into a thin cord, a condition which was explained by the history of an attack of phlebitis in that vessel five years before death. Mr. Shaw alluded to two other cases, somewhat resembling the above, which had recently fallen under his notice.—*Medical Times and Gazette.*

Skin Diseases treated by Ointment of Sulphate of Iron.—In the *Journal de Médicine et de Chirurgie Pratiques* for January, 1855, M. Devergie recommends the use, in some cutaneous diseases, of an ointment of sulphate of iron, prepared according to the following formula:—

Crystallised and washed protosulphate of iron, 5 *decigrammes*, (gr. viii.) to 1 *gramme* (gr. xvss.)

Lard, 30 *grammes* (ʒ xviiss.)

Of his success with this remedy, M. Devergie thus speaks:—

Ointment of sulphate of iron is most successful in eczema, eczema impetiginodes, impetigo, and intertrigo. Obstinate eczema of the scrotum has several times been removed by the use of this ointment. After the acute stage is passed, the iron ointment, spread on lint, has produced good results in removing the indurations which accompany or succeed the vesicles and pustules of rupia and cachectic ecthyma. Little or no effect has been produced in lichen, except in *lichen agrius*, and in some cases of eczematous lichen; the ointment is also of no avail in psoriasis, lepra vulgaris, ichthyosis, and chronic pityriasis. It is injurious in bullæ or essentially vesicular affections, such as pemphigus, herpes, when the vesicles are large; as well as in acute ecthyma, acne rosacea, pustular or tuberculous mentagra, whether in the acute or in the suppurative stage.

New Treatment of Coryza.—In the *Journal de Médecine et de Chirurgie Pratiques* for November, 1854, M. Yvonneau adds another plan of treatment to the many which have been recommended in cases of coryza. He says that he has obtained great success by plugging up the external nares by introducing a plug of lint rolled in collodion. The organ, he says, is protected from the contact of cold air, and at the same time, the disordered surface is bathed in warm air and the moisture exhaled in respiration. The remedy has, in his hands, never failed to produce a cure in twenty-four hours.

On Fœtal Luxations, and especially on the Congenital Sub-coracoidal Luxation of the Humerus, &c. By Dr. A. Mayer of Würzburg.—The luxations of the unborn child are obviously to be distinguished from those occasioned during labour, and call for a widely different treatment. Dr. Mayer gives a short historical retrospect of the first kind of luxations. He states that during his own thirty years' orthopædic experience, thirty-six real fœtal luxations have come before him.

a. Three were left shoulder dislocations forwards.

b. One complete symmetrical dislocation of both humeri at the elbow-joints in a man of twenty-seven.

c. One symmetrical luxation of the heads of both humeri backwards and outwards in a child three weeks old, who bore at the same time many other distortions.

d. Of luxations in the joints of the hand he has observed seven.

e. One incomplete luxation of the left patella outwards, which had remained unheeded eleven years.

f. One complete luxation of the left knee inwards, with secondary, acute-angled anchylosis of the tibia backwards.

g. Fourteen luxations of the hip-joint; of these, nine were symmetrical, five one-sided.

Dr. Mayer has seen but three cases of congenital dislocation of the shoulder-joint; all were on the left side; in all the head of the humerus was thrown forwards, under the coracoid process, and a tolerably perfect new joint had formed on the anterior surface of the scapula. The first case was complicated with many defects of development. The child died of atelectasis in two hours. The second case was seen in a man thirty-six years old, who was content to bear with his atrophied arm. The third case was the son of a healthy man, but his mother had died, a few weeks after his birth, of caries of the spine and hectic. The patient was twenty-four years old. Before detailing this case, Dr. Mayer refers to the treatises of R. W. Smith of Dublin, Melicher, Malgaigne' d'Ontrepont, Dupuytren, and Ammon, upon similar luxations. In his own case he found the left shoulder almost atrophied to a skeleton. This atrophy extended to the arm, but in lesser degree to the fore arm. There was but limited motion in the shoulder. The acromion projected considerably, and underneath, instead of the head of the humerus, the finger sank into an empty cavity. The deltoid was so atrophied, that it could scarcely be made out. The head of the humerus lay under the coracoid process in an abnormal flat joint on the fore part of the scapula, and on the ribs. Abduction and elevation of the arm impossible for the patient, but slight motion can be given by the surgeon. A minute comparison of the dimensions of the two arms showed that all the dimensions of the left arm were sensibly less than those of the right.

The causes of this luxation are predisposing, or occasional. These we pass over as being chiefly hypothetical. The operation Dr. Mayer recommends for the relief of this deformity he calls *osteotomia angularis partialis scapulæ.* He describes six stages in its performance. 1. Division of the skin and sub-scapularis. 2. Trepanning the spine of the scapulæ. 3. Sawing out of the wedge of bone. 4. Sawing through between the coracoid process and the neck of the scapula. 5. Breaking the joint-pan, and removal of head of scapula. 6. Uniting the wound and dressing. Although Dr. Mayer describes this operation as if it had been performed upon the living subject, it is not stated to have been performed in the case minutely detailed as to anatomical diagnosis; nor is anything said about observed results of the operation.—*Verh. d. Phys. Med. Ges.*, Band v. Heft. ii. 1854, and *Brit. and For. Med. Chir. Rev.*

DUBLIN: PUBLISHED BY W. B. KELLY,
8, Grafton-street.
LONDON: S. HIGHLEY, 32, Fleet-street.
EDINBURGH: MACLACHLAN & STEWART.
May 1, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.

SENT FREE BY POST.

Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 8.—Vol. II. • MAY 15, 1855. Price 5d.

RICHMOND SURGICAL HOSPITAL.

Case of Wound of the right Side of the Neck with a Case Knife, transfixing the Œsophagus, and wounding the left Pleura and Apex of the Lung; with fatal Issue.

BY EDWARD HUTTON, M.D.,

SURGEON TO THE HOSPITAL.

Catherine Kavanagh, æt. 22, presented herself at the Richmond Surgical Hospital, on Monday the 19th of March, 1855, at six o'clock, P.M. In an altercation with another woman she had received a wound, three-fourths of an inch long, on the internal side of the right sterno-mastoid muscle, a little more than an inch below the inferior margin of the thyroid cartilage. A probe was introduced into the wound, which, however, did not make its way to any depth. There was then no indication of any wound of the trachea, the respiration being unaffected, and there was scarcely any hæmorrhage; under these circumstances the wound was dressed, and she was allowed to depart in custody of the police. About an hour afterwards she was brought back much changed for the worse; she was very weak and pale, and had hurried breathing. There was an emphysematous swelling for some space around the wound. The patient was immediately admitted, and Dr. Hutton was apprised of the case. When he arrived at the hospital she was asleep, lying on her back, with her head turned to the right side; the eyes half open; the countenance pale, and expressive of distress, but her respiration was not so disturbed as it had been. The wound was as before described. Dr. Hutton introduced the point of his forefinger into the wound, and found the side of the trachea quite bare, the knife having passed through the sterno-thyroid and hyoid muscles. He thought that he felt some irregularity on the side of the trachea, and from the emphysema concluded that the trachea had been wounded. On giving her some water to drink it gushed out immediately from the wound, together with some bubbles of air. Dr. Hutton expressed his fear that the œsophagus was also wounded, but remarked that, in some cases of wounds of the trachea *alone*, as after the operation of tracheotomy, liquids swallowed sometimes flowed out at the wound. It was directed to give her drink from an elastic bottle, through a tube, passed down the œsophagus. This was attempted by the resident pupil, but found impracticable from the obstruction which the attempt occasioned to her respiration. On the next day the report was that she had had a restless night, felt weak, and complained of pains in her back and head. At the time of Dr. Hutton's visit she was sitting up, supported by a bed-rest and pillows. Her face was much flushed, of a dark-red hue, and she complained of pain in her head. Her breathing seemed more easy; there was little or no emphysematous swelling about the wound; the pulse was frequent and weak, and she looked ill. In the latter part of this day her breathing became very hurried, and her pulse rose to 140; and after a restless night she died at about half-past eight o'clock, A.M. on the following morning, thirty-eight hours and half after the receipt of the injury.

Post Mortem Examination.—The course of the knife in inflicting this wound, was as follows:—It passed through the integuments, platysma, fascia, sterno-thyroid and hyoid muscles, to the outside of the trachea, without wounding this tube; traversed the œsophagus at its anterior part from right to left, and obliquely from above downwards; passed to the left side of the neck, and penetrating the cone of the left pleura, inflicted a wound on the apex of the left lung. This latter wound was about one-fourth of an inch in extent, and very superficial; slight induration surrounded the puncture from extravasated blood. The left pleura contained a large quantity of serum, mixed with lymph, and also air. The lung was collapsed, and had patches of lymph on its surface. The mucous membrane lining the trachea was very vascular. There was no artery or vein of importance wounded.

Remarks.—In the systematic works on Surgery, a wound of this nature, involving the pleura and lung in the neck, has not been described, or even contemplated, except in the operation for tying the subclavian in the first part of its course, or in removing tumours from the base of the neck, in which cases the pleura has been wounded. In this case the left pleura and lung ascended in the neck unusually high, to at least the fifth vertebra, and was therefore liable to be wounded by a penetrating instrument entering so high as the site of the wound here described. The case seems to be of some importance, as it seemed at first view much more probable that the emphysema, which was limited in extent and duration, arose from a wound of the trachea than from that of the lung; the tube was, however, altogether intact, and the fatal issue of the case was the result of the injury of the lung.

MEATH HOSPITAL.

Case of Cirrhosis of the Liver, with Observations on its Treatment.

BY DOCTOR LEES.

Reported by MR. FREDERICK WILSON.

A married woman, æt. 38, was admitted to the Meath Hospital with great enlargement of the abdomen; this depended partly on the presence of air, and partly on fluid, as a tympanitic sound was elicited by percussion on the anterior part of the abdomen, while that over the sides was very dull, and here the sense of fluctuation was quite perceptible; the veins over the abdomen were much distended; and in the left hypochondrium a hard moveable tumour could be distinctly felt; there was no tenderness on pressure; the legs and feet were slightly œdematous; the face and upper extremities were very pale, emaciated, and did not present the slightest trace of jaundice; the skin was very dry; the urinary secretion scanty, highly acid, 1.028, depositing, on cooling, a copious reddish sediment which cleared by heat. She stated that she had seven children, and was of temperate habits, but badly nourished; that her menstrual discharge had ceased five months ago, immediately after which her abdomen began to swell without any pain or constitutional disturbance. The distress now caused by the increase of fluid was so great, that paracentesis was performed by Mr. Collis with much relief, and a quantity of clear, highly albuminous fluid drawn off; this increased rapidly again, however, and necessitated a repetition of the operation in about ten days; she now suffered slight uneasiness for two or three days at the seat of puncture, but this subsided, and she appeared to be going on well, when she was suddenly attacked on the ninth day after the last operation with violent acute pain in the left hypochondrium, and sunk rapidly with the ordinary symptoms of acute peritonitis.

On opening the abdomen, a great quantity of clear serous fluid escaped; the spleen now came in sight, greatly enlarged, forming the tumour in the left hypochondrium, the stomach appeared greatly distended; the liver was concealed out of sight under the right false ribs, and on being taken out, was found to be very small, nodulated, and rough, of a pale reddish colour; the gall-bladder contained a normal quantity of dark bile. There was slight vascularity with exudation of lymph over the abdominal peritoneum in the left hypochondrium, but at the right side, when the small puncture of the operation could be seen, there was not the slightest trace of inflammation. The surface of a section of the liver presented a hard grisly stroma, which Mr. Thomas Hayden kindly submitted to a careful microscopic examination, and forwarded me the subjoined report:—

"A section of the liver, placed in the field of the microscope, and examined with a magnifying power of 325 deg., exhibited what appeared at first sight little else than a universal stratum of oil globules, but on clear inspection these were ascertained to be the hepatic cells distended with oil—first, from the almost total absence of normal cells, a few only remaining, which afforded the advantage of comparison; second, from the cell-wall being distinctly recognizable, and, in some instances, the nucleus compressed between the latter and the oil-bleb: from this circumstance I am led to conclude that the liquid fat was not diffused within the cell, but was contained in a proper capsule, that it was, in fact, an exaggeration of the fat-globules found in the healthy hepatic cell. The size of these enlarged cells, as ascertained by my micrometric rule, averaged 1.1300th part of an inch, while that of cells obtained from a healthy liver I found to be 1.1950th of an inch. It is difficult to conceive how cells so distended (with the nucleus in some obliterated, and in most dislocated and compressed) could discharge a secretory function."

This case, although one of a very common disease, and not presenting any difficulty in the diagnosis, yet I think may furnish us with some interesting points for consideration. First, as regards its morbid anatomy. The prevalent opinion is that of Carswell, who considers it to consist in atrophy of the lobular structure of the liver, produced by a contractile fibrous tissue, originating in inflammation of the capsule of Glisson, which may be seen forming white lines (like the seams of a cicatrix) round the acini, and which by its contraction causes compression of the secretory cells, and general atrophy of the liver. Some pathologists consider this fibrous tissue as the result of inflammation, while others regard it more as the product of a degenerative process, resulting from some peculiar non-inflammatory exudation, which may be placed in the same category with the tubercular, the atheromatous, and cancerous formations, though presenting distinctive characters of its own. Dr. H. Jones supports this view, and designates it as a fibroid degeneration, owing to the crasis of the blood being changed, that this fluid comes to be in that condition which Rokitansky denominates the fibrinous crasis, and that the change is analogous to that which occurs in cartilaginous induration of the capsule of the spleen, and similar depositions in the valves of the heart, which we can scarcely regard as the result of ordinary inflammation. The history of this case would seem to support his view, as though this condition of the liver is in many cases the "wages" of intemperate habits, and is justly termed the whiskey liver, yet this patient had always been temperate, and had never suffered from any inflammatory symptoms. The appearance of the acini of the liver, some of which were evidently enlarged, the condition of the cells, as seen under the microscope in this case, and the persistence of the normal secretion of bile, would tend to militate against the theory of their being compressed by the fibroid tissue, unless we adopt the opinion of Cruveilhier, who suggests that cirrhosis may consist in an excessive development of a portion of the granules of the liver, consequent upon atrophy of the remainder, or the theory lately propounded by Dr. Gairdner, who considers that the atrophy commences in the glandular epithelium, and thus gives rise to an apparent relative hypertrophy of the fibrous tissue. With reference to the diagnosis of this disease, Dr. Budd truly observes, "that in its early stage the symptoms are, in most cases, few and obscure, presenting no distinctive characters," in fact, its existence at an early period is rather to be inferred than positively demonstrated, and it often occurs, that it is only when the fibrine effused in the substance of the liver has interfered with the circulation of the portal blood, and the congested capillaries have relieved themselves by effusion of serum into the peritoneal cavity, that the occurrence of ascites is the first sign which directs our attention to this disease of the liver; but we are sometimes deprived of even this assistance to guide us in the diagnosis, a good illustration of which was exhibited at the Dublin Pathological Society by Dr. Gordon, in the case of a boy 15 years of age, "who had neither jaundice, dropsy, pain in the shoulder or side, nor any other symptoms from which disease of the liver could be inferred with any degree of certainty," and yet the liver presented well marked appearance of cirrhosis. Dr. Banks also exhibited another specimen of cirrhosis, in which there was no ascites present, but in both of these cases there was enlargement of the spleen, which indeed has been observed in every case of cirrhosis of the liver which has occurred in Dublin, and which we therefore regard as a most important sign to aid us in our diagnosis. It is remarkable that Dr. Budd states that the spleen is not enlarged in cirrhosis, which certainly is contrary to our experience. In most cases, also, there is some form of hæmorrhage either from the nose, skin, or stomach and bowels; in this case there was none, probably owing to the great size of the spleen, which acted as a diverticulum. The condition of the urine is, I feel confident, a valuable aid to our diagnosis, as in almost every case it is very high-coloured, and presents a copious deposit of purpurates, but does not contain albumen. In this case, as in most of the cases I have seen, the stomach was greatly dilated, but there was no organic disease of this viscus, which I consider is a rare complication, though Dr. Budd states the contrary. It is a curious fact,* related by Dr. MacLean, of the Madras Medical Service, that "cirrhosis does not form a separate item in the Indian returns," although it is a very common disease, owing to the number of inveterate spirit drinkers in that country." He says that "men labouring under cirrhosis in its early stages, before a mechanical obstacle to the free circulation of the blood through the liver exists to any great extent, are often treated in hospital, the treatment being directed to prevent suppuration, to *which there is no tendency in this disease at all*, and this not occurring, they are, after a time, dismissed as 'cured.' Again and again they are admitted, so treated, and so dismissed, until at last the mechanical obstacle to the free circulation of blood through the gland is so complete, that ascites is the inevitable result; they die, and the fatal event is recorded under another head, and is not debited, as it should be, to the account of disease of the liver."

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* Indian Annals of Medical Science, October, 1854.

These facts are of the greatest importance with regard to the exhibition of mercury in this disease, which medicine is unfortunately too often used in an indiscriminate manner, and with very undefined notions as to a certain specific influence which it is supposed to exert over all the morbid conditions of the liver. Dr. Budd advises blue pill to be given in moderate doses, so as slightly to affect the mouth; but I confess I do not approve of this practice, for in the cases caused by intemperance, the patient's blood is already, to a certain extent, poisoned by alcohol, and I do not think it likely to be improved by a course of mercury, and in the class of cases depending on degenerative action, the most sanguine supporter of mercury could scarcely justify its use. Our chief efforts should be directed to correct the condition of the blood, and improve the general system by temperance, good diet, and healthful exercise; while with regard to medicine, I think that the so-called depurating, or chemical diuretics, especially the salts of potash, combined with vegetable acids, as recommended by the late Dr. Golding Bird, will prove the safest and most effectual remedies.

WHITWORTH AND HARDWICKE HOSPITALS.

On some unusual Terminations of Caries of the Temporal Bone.

BY DR. M'DOWEL,

PHYSICIAN TO THE HOSPITALS.

It is well known that some of the most fatal affections of the brain and its membranes are the result of various forms of *Otitis*. Caries of the temporal bone in its progressive march often implicates the membranes, and subsequently the brain itself, in fatal disease. But it should be borne in mind that even inflammation of the cavity of the tympanum, unaccompanied by disease of its osseous walls, may prove fatal in a similar manner. An example of this occurrence was brought before the Pathological Society, by Dr. Hutton, in 1844.[*] The subject of the case was a boy nine years of age, who, for a long period, had a discharge from the ear. Symptoms of arachnitis supervened, and he died comatose. Ten days previously the discharge from the ear was almost completely suppressed. "In examining the body after death, the meatus externus of the affected ear was found filled with caseous matter; there was an opening in the membrana tympani, and at the insertion of the membrane there was a fungous growth; the mucous membrane lining the cavity of the tympanum was thickened and granular, it adhered firmly to the bones; the ossicula remained. The *temporal bone itself was not carious*, nor softened, nor was its mastoid process at all diseased; the dura mater was separated from the petrous portion, and lymph was effused between them. The dura mater was sloughy; the upper surface of the cerebellum was smeared with purulent matter, the inferior surface of the tentorium was similarly smeared; the brain was not softened. *No communication could be traced between the cavity of the cranium and the internal ear.*"

The secondary lesion in such a case would by many be regarded as the result of metastasis, consequent on the suppression of the external discharge, but I would be more disposed to regard the cerebral mischief as the result of phlebitic inflammation originating in the veins of the osseous tissue, which veins, it may be incidentally observed, are extremely prone to suppurative inflammation.

It is this liability to the supervention of fatal cerebral disease which invests *every case* of chronic otorrhœa with painful interest.

The secondary affections to which death may be directly owing in cases of caries of the temporal bone, are by no means uniform in their necrology. The following are the principal which have hitherto been observed:—

I. By inflammation and sloughing of the dura mater, and consequent suppuration of the brain, the morbid action having extended by continuity from one tissue to the next. This is the most frequent cause of death in such cases.

II. More rarely, instances have been met with in which fatal disease of the brain has occurred, without there being any direct communication with the diseased bone.

III. Caries of the temporal bone has proved fatal by inducing inflammation of the lateral sinus, followed by the train of symptoms which usually accompany fatal suppurative phlebitis.

It has occurred to me to meet with two instances in which disease of the internal ear proved fatal in a manner differing from any of the preceding. In one of these, death was owing to universal cerebro-spinal arachnitis, without any lesion of the brain. In the other, the fatal result was owing to *perforation of the lateral sinus*, and purulent infection of the blood from the direct introduction of pus from the diseased bone into the circulation.

CASE I.—*Chronic Otorrhœa; Caries of the Temporal bone; Cerebro-spinal Arachnitis.*

Margaret Usher, æt. 12, admitted into the Harwicke Hospital, labouring under the symptoms of fever. She had been ill for one week; there was a discharge of fœtid pus from the left ear, and a puffy tumour over the mastoid process. The patient seemed to suffer great pain, which she referred chiefly to her back and lower limbs; when she was placed sitting up in bed, she screamed with agony. The head was retracted and rigidly fixed by the contracted condition of the muscles of the nucha. There was likewise "exalted sensibility" of the surface to a remarkable degree. The slightest pressure on almost any part of the body caused her to complain loudly, and the nurse said that the girl would hardly allow her to touch her.

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[*] *Vide* Transactions of the Pathological Society, vol. i. p. 287.

The *previous history* of the case was briefly the following:—She had suffered from otorrhœa for three years, and in consequence her hearing was much impaired. There had been discharge from both ears, but when she took sick, the discharge from the right ear ceased. For a month before her admission, she had complained of headache.

Progress of the Case.—Two days after admission, facial palsy was observed on the right side. The girl slept very little, and disturbed the other patients by her cries and screams. Pain in the back continued to be her chief complaint. There was a wild expression of countenance, but she answered all questions sensibly. At night there was delirium.

The periosteum over the mastoid process was freely divided, and some pus given exit to. Leeches were several times applied over the spine, and subsequently blisters, whilst mercury (hydrargyrum c. creta) was freely given, and its use persevered in until it ran off by the bowels. On the sixth day, no improvement had taken place. The patient was much emaciated, and occasionally vomited; the discharge from the abscess had ceased, but that from the meatus was profuse and fœtid; the breathing was now observed to be somewhat embarrassed.

The patient continued to sink; the retraction of the head became even more pronounced, whilst the hyper-sensibility of the surface diminished; the dyspnœa became greater, and death occurred on the eleventh day after admission. Convulsions did not occur.

Autopsy.—*Cranial Cavity.*—The petrous portion of the right temporal bone was extensively carious; on its upper surface was a large perforation. The dura mater corresponding to the diseased bone was in a sloughy condition; it was of a greenish colour and pulpy consistence.

The *brain* was more vascular than natural. Lymph in large quantity was effused beneath the arachnoid around the pons varolii, cerebellum, and medulla oblongata.

Spinal Canal.—The theca vertebralis showed numerous distended vessels on its exterior. Internally the cord and pia mater were found bathed in puriform matter, which flowed out when the sheath was opened inferiorly. The exterior of the cord was likewise smeared over with lymph of a greenish yellow colour, which was universally effused in the subarachnoid space. The cord itself was perfectly healthy.

It thus appears that cerebro-spinal arachnitis may not only occur as an idiopathic affection, but may become developed as the result of inflammation of contiguous structures.

CASE II.—*Chronic Otorrhœa; Caries of the Temporal Bone; Perforation of the lateral Sinus; Death from purulent Infection of the Blood.*

The history of the case was as follows:—A boy, 13 years of age, had for ten years laboured under otorrhœa; with the exception of deafness on the affected side (the right), there was no other symptom. A fortnight before he came under observation, whilst in school, he was struck somewhat sharply on the right ear by the schoolmaster; a few dops of blood escaped from the meatus. Four days afterwards he began to complain of his head, and vomited. He was at this time under the care of Dr. Byrne, of Westland Row (to whom I am indebted for the foregoing facts), and by his advice was transferred to hospital.

On admission into the Whitworth Hospital (Dec. 3rd, 1854), there were but few symptoms to attract attention. There was no headache; the boy was perfectly sensible, and the pulse was not above 90; but there was a slight degree of stupor present; and it was reported that the boy raved and occasionally screamed out during the night. It was also observed that there was a total cessation of all discharge from the ear. On the day following, his symptoms had undergone a complete change; the pulse was now excessively rapid (150—160); the respiration was proportionably accelerated, and was accompanied by a cough. The surface of the body laterally and posteriorly presented a peculiar violet hue, such as is rarely seen except after death. There was no tendency to coma; no complaint of pain, and yet the boy was obviously in a dying state, though from what cause death was impending, it was not easy to determine.

He continued to sink rapidly, and died on the day following (Dec. 5th).

Post Mortem Examination.—On removing the calvaria nothing morbid was observed; the dura mater covering the temporal bones was healthy in colour and consistence, but so fœtid an odour was observed that a careful examination was instituted. At last, on opening up the right lateral sinus, we found the mastoid portion of the temporal bone *beneath* the sinus perfectly bare (the layer of dura mater covering it having been destroyed), whilst a round opening of small size led from the interior of the bone, which was excavated by caries, into the cavity of the sinus. A soft coagulum occupied the venous channel. On the corresponding portion of the cerebellum, a greenish discoloration became developed after the brain had been for a little while exposed to both air and light. It certainly did not exist when the brain was examined immediately after its removal from the cranium. There was no meningitis.

On the surface of both lungs were numerous gangrenous spots of various sizes. Over each of these the pleura was elevated, forming a dark bulla, which contained fetid air and sanies, and the surface of the lung beneath was sloughy; some of these bullæ were as large as a walnut. There were besides numerous dark spots of ecchymosis scattered over the lungs, but no purulent deposits. There was much pulmonary congestion.

The *temporal bone* was extensively diseased. The mucous membrane of the meatus and of the tympanum was thickened and granular. A mere shred of the membrana tympani remained. The mastoid cells were excavated by caries, and filled with pus and lymph; the partition between the tympanum and vestibule was destroyed, ulcerative process extended thence along the course of the aqueduct of the vestibule, and opened into the lateral sinus, just above the foramen lacerum posterius.

Remarks.—In some cases of purulent infection of the blood, it is a matter of some difficulty to determine the origin of the disease; to decide with certainty who were "the traitors that admitted this deadly enemy into the citadel of life;* but in the present instance no such uncertainty existed; the opening was manifest by which the pus from the diseased bone obtained admission into the venous circulation.

The effects upon the system were wholly unlike those which are usually met with as the result of inoculation with purulent matter. No "multiple abscesses" were found, nor inflammations of the serous or synovial membranes.

Death occurred with greater rapidity than is ever observed in pyæmia, and was *directly* the result, as I believe, of the introduction into the system of a powerful septic poison, composed of putrid gases, and of unhealthy pus from the carious bone. Of this, the gangrenous state of the lungs and the cadaveric hue of the skin were evidences. Indeed, the universal dissemination of the gangrenous bullæ over *all parts* of the surface of *both lungs*, indicated plainly the *blood origin* of the disease.

It would appear that in this instance death was not attributable to any one lesion, but was chiefly the result of a peculiar form of *putro-adynamic* fever, accompanied by the sudden and rapid sinking of all the vital powers. Similar symptoms have been observed by physiologists to be the result, when putrid matters have been injected into the veins of animals. Such experiments have been performed by Magendie, Gendrin, Gaspard, and others. These physiologists have fully proved that such substances, when thus introduced into the system, produce symptoms similar to those of typhus, and that after death, the blood is found fluid, of a dark colour, and exuding from the capillaries, both into the parenchyma of the viscera, and from the mucous surfaces. The following experiment from Gendrin may be taken as an illustration:—

"'A flayer' was affected with putrid fever and gangrenous pustules; his breath, evacuations, and whole body were horribly fœtid, and blood taken from a vein was, three hours and a half afterwards, unusually dissolved and black, and gave out a putrid odour." M. Gendrin introduced some of this blood into the cellular tissue of a cat, and into the femoral vein of a dog. "Both animals evinced symptoms of putrid fever, and died in a few hours. The blood throughout their bodies was dark and fluid, the viscera congested and ecchymosed with dark spots, and speedily began to exhale a fœtid odour."

I have already mentioned that caries of the temporal bone may prove fatal by inducing inflammation of the lateral sinus, an example of which was laid before the Pathological Society by Professor Smith, in 1840. Several cases further illustrating the pathology of this affection have since then been recorded by Mr. Toynbee, Watson, and others.* In all of those the usual results of phlebitis was developed, and death was owing to pyæmia. In Professor Smith's case, for example, the membranous walls of the right lateral sinus were much thickened, their lining membrane being covered with lymph of a greenish colour, and smeared with an unhealthy, purulent matter. This condition of the lining membrane extended along the jugular vein and superior vena cava, to within a short distance of the entrance of the latter into the auricle.

"The left cavity of the pleura contained about four ounces of thin fœtid matter, and lymph was effused on both layers of the membrane. The lungs were solidified inferiorly, and small circumscribed deposits of purulent matter were scattered through them. In two instances a small branch of a vein was distinctly traced, opening into these deposits; these veins were inflamed, and contained pus. Lymph also was found upon the surface of the heart." The morbid appearances in the case which I have detailed in the preceding pages were altogether different. In those cases where the lateral sinus became involved in the progress of caries, the pus by which the system was contaminated was *secreted within the sinus*, and death was produced by the secondary affections which usually attend pyæmia. In the case which I have recorded, pus was *introduced into the venous channel from without*, and owing to the putrescent nature of the matter thus introduced, the lungs through which the poisoned current first passed, were so universally disorganized that death ensued before the other lesions (which more usually accompany purulent infection) had time to become developed.

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* Solly.

* See also a recent valuable communication by Dr. Gull to the Med. Chirurg. Society.

Fatty Degeneration of the Heart; Pulmonary Apoplexy.

BY DR. GORDON,

PHYSICIAN TO THE HOSPITALS.

James Dolan, æt. 41, formerly in very comfortable circumstances, but latterly much reduced by intemperance, which for the last three weeks he has carried to excess, was admitted into hospital, March 22, complaining of cough and intense difficulty of breathing; he was of a remarkably pale and anæmic appearance; his pulse was intermitting and exceedingly feeble; his extremities cold, his lips very slightly livid; his chest bore the marks of his having repeatedly undergone the operation of cupping; there were sonorous and sibilous râles audible over both lungs. The cough was a short, teazing, hollow-sounding cough, with but little expectoration, and that white, viscid, and glairy, slightly tenacious; the dyspnœa was greatly relieved when he got into the recumbent posture, but was again increased on any exertion. The nature of the case was not very difficult of diagnosis. The extreme debility and intermission of the pulse were clearly owing to cardiac degeneration; it had none of the irritability or hæmorrhagic character which is induced by hæmorrhage, and which was the first idea likely to be suggested by this man's appearance. The cardiac debility was evidently not caused by engorgement from pulmonary obstruction, for excepting very slight lividity of the lips, there was no symptom of the circulation of blood which was not sufficiently oxygenated; but there was also the peculiar character of respiration in this patient, which is very indicative, if not pathognomonic of cardiac dyspnœa, and has been described by Dr. Stokes in his work on the "Diseases of the Heart and Aorta," as almost pathognomonic of fatty degeneration of the heart. He describes it as consisting "in the occurrence of a series of inspirations increasing to a maximum, and then declining in force and length, until a state of apparent apnœa is established." In the present case it did not arrive at this extreme, but the long series of inspirations, with one prolonged expiration, was very well marked, and this occurrence took place repeatedly, and the respiratory process then returned to its usual accelerated state. There were no physical phenomena in the lungs to account for this dyspnœa; there were merely the râles usually indicative of slight bronchitic inflammation or congestion, and which, in the present instance, from the marks of long-continued treatment, we conceived to be of a chronic character. There was this unusual phenomenon, however, present, as carefully remarked by the clinical clerk, Mr. Abbott, that the expiratory murmur was greatly prolonged. This character of puerility of respiration has also been alluded to by Dr. Stokes, in his observations on Fatty Degeneration of the Heart.

The treatment adopted in this case consisted in the administration of large doses of wine, with extensive counter-irritation over the entire thoracic region, but over the cardiac region in particular.

In the course of the evening there was a remarkable change in the symptoms. He suddenly complained of intense pain in the left side; his countenance became greatly congested, forming a remarkable contrast with his former anæmic appearance; his breathing became intensely difficult, and his cough almost incessant; the expectoration also became bloody. He died in the course of that night rather suddenly.

Post-mortem Examination.—There was a considerable quantity of air in the cellular tissue of the anterior mediastinum; there was air also in the heart and in the large vessels at the root of the neck; the walls of the heart were exceedingly thin, and the entire organ was covered with a layer of fat; in the right ventricle there was scarcely any remains of muscular structure, so complete was the degeneration into fat; the left ventricle had also undergone great degeneration, but not so much as the right. There was a considerable quantity of fluid blood in the vessels, and oil-globules were visible floating in it in great number.

The right lung was healthy, excepting slight redness of the bronchial mucous membrane; the left lung was the seat of several apoplectic nodules of various sizes,—one very extensive, about the size of a small hen egg, was close to the surface of the lung—and over this, and for some extent beyond it, the pleura had been forcibly separated from the lung, but had not been ruptured; the costal pleura was unattached and perfect; there was some blood still fluid beneath this detached pleura; these apoplectic nodules existed chiefly towards the base of the lung, and the bronchial mucous membrane in this part was of a deep red colour; the upper part of the lung was healthy.

Although several cases have been detailed from time to time of fatty degeneration of the heart which have had their fatal termination in cerebral apoplexy, it is comparatively new to find fatty degeneration of the heart producing *pulmonary* apoplexy. This is the more remarkable, because, in general, it is found that the right ventricle of the heart is that which has undergone most or even all the fatty degeneration; and although the apoplexy is, perhaps, immediately produced by obstruction from remora or stasis *anteriorly*, it is no doubt caused in a great degree by the want of a sufficient *vis a tergo*.

The degree of pulmonary hæmorrhage, and the force with which the blood was poured out, must have, in this case, been very considerable to tear up the pleura to the extent that occurred. The time that this took place was evidently when he was seized with the acute pain in his side a few hours before his death. The presence of air in the anterior mediastinum, and other parts of the body, its existence in the large vessels and heart, and the free oil in the blood, are now familiar to all physicians as frequent concomitants on this cardiac degeneration.

ROYAL INFIRMARY.

Chronic Disease of Head of Femur; Lodgment of a Musket Ball in it for twelve Years.

BY WILLIAM K. SWETTENHAM, M.D.,

STAFF SURGEON AND PRINCIPAL MEDICAL OFFICER TO THE ROYAL INFIRMARY.

Martin Feeny, æt. 39, 3rd Buffs, was admitted into the General Military Hospital, Dublin, February 1st; a labourer prior to entering the service, in which he has been twenty years; states that he received a gun-shot wound at the action of Punniar, in India, 29th Dec., 1843, the cicatrix of which was observed to be a hand's breadth below the crest of the ilium, and in front of the great trochanter of left side, this being the aperture of inlet of the ball, which he stated was never extracted, and therefore no aperture of exit remained. This man formed one of a party of sick of the depot, 3rd Buffs, marching from Newry to Kinsale, and in passing through Dublin was lodged in the above hospital, but found unable to proceed on the following morning from extreme debility. He had then diarrhœa with fever, indicated by foul white tongue and rapid pulse; a fistulous orifice existed at the cicatrix of the wound, discharging copiously thick pus; a probe introduced into this orifice was felt to grate on denuded bone, and to pass easily downwards in front of the thigh, where existed a large fluctuating tumour; this was diagnosed as a large abscess deeply seated under the muscles in front of the left thigh, and extending downwards to the inferior third of the limb; an incision, small and valvular, was made into the thinnest, which was also the most depending part, and matter allowed to escape gradually. Carminative medicine was administered, and poultices applied. He is reported going on pretty well up to Feb. 7. The diarrhœa controlled and fever less; allowed nourishment, with wine. Again, on the 12th, diarrhœa returned, reducing his pulse considerably; there is a bad fœtor about him, with copious discharge from the abscess, and slough forming on the sacrum; muttering delirium setting in. The usual palliative remedies were adopted; he was ordered acetate of lead with opiates; he continued in this semi-comatose state, constantly muttering, and taking chiefly wine as nourishment up to the 15th. Having passed, during the previous night, involuntarily, a quantity of urine which seemed to contain pus, he died on the fifteenth day, at three o'clock, P.M. This man is stated to have performed his duties, with slight intervals of outbreak of the wound, up to the day of his admission into hospital.

Post Mortem Examination twenty-two hours after death.—Head and thorax were not examined. The body much emaciated, and large black slough on the sacrum. The course of the abscess in front of the thigh being laid open, the muscles of the limb were found completely dissected from the bone, which, down to its inferior third, was denuded of its periosteal covering. The capsule of the hip joint was found thickened and perforated in two or three places anteriorly and posteriorly; the neck of the femur anteriorly, and the great trochanter posteriorly, completely deprived of their periosteal coat, presented to view the well-marked appearance of diseased bone, resembling the partial solution of loaf sugar in a fluid; the cartilage of the head of the femur being also partially ulcerated. The ball never having being extracted, was searched for, and after some examination its situation was detected by the observance of a small orifice (capable of admitting only a small sized probe), in the direction of the head of the great trochanter, in the immediate vicinity of which is thrown out an accessory piece of bone like the lesser trochanter. This caused me to excise a wedge-shaped portion of the bone, and the musket ball was found neatly imbedded in the head of the great trochanter, very little altered in its shape. A quantity of purulent matter was found in the medullary canal of the bone. The bladder was examined and found to contain the same muddy urine as he passed, but there was no disease visible in this viscus or in the pelvis. *The specimen was presented to the museum of the Richmond Hospital.*

Extract of a Paper on Jewish Leprosy.

BY DR. ROBERT MACDERMOTT.

[Read at a Meeting of the Dublin University Philosophical Society, April 2nd, 1855.]

The subject of the Jewish leprosy has been always one of considerable difficulty to investigators, as well from the obscurity of original accounts, as from the futile attempts made by medical writers to identify the characters delineated in Holy Writ with the existing types of cutaneous disease.

We owe much of this embarrassment to the early Greek physicians, who drew their material less from their own private observations, than from the confused and exaggerated narratives of Eastern travellers. There is very little doubt that no disease which could be strictly identified with the Jewish leprosy, or plague of Cœle-Syria, existed in the Peloponnessus, in Northern Greece, or on the shores of Asia Minor, as early as the third century B. C. On the establishment of the Alexandrian dynasty, many of the Greek physicians who attended the courts of the Ptolemies had opportunities of observing the forms of leprosy which then infected the shores of the Nile, but at the same time confounded it with the Elephantiasis Græcorum, prevalent in those regions, and described as the Jewish malady, by writers of the middle ages.

The accurate description of the disease given in the book of Leviticus seems to have been unknown to them—at least no allusion to it is made in their writings, a fact the more to be wondered at, as the date of the Septuagint version of the Old Testament can scarcely be placed lower than B. C. 270. Those phrases descriptive of the disease which they borrowed from the Semitic dialects, helped to increase the perplexity by their improper application. The early Latin and Arabic writers followed with blind veneration in their footsteps, and described as leprosy a totally different class of diseases. This error was followed by the most fatal consequences to society in the early ages of Christianity. The Jews, at all times a disturbed and persecuted race, were supposed to have infected Christians with that terrible disease, the everlasting type of their revolt and degradation; the unhappy victims who had contracted the affection were looked upon as the special objects of divine wrath, who had brought down this scourge upon themselves by the enormity of their guilt. Lepers, as they were called, were shunned with a fear more of moral than of physical infection, and these miserable beings were separated by the most stringent laws from any communion with their fellow-men.

On a careful examination of those passages in which the leprosy is mentioned, it would appear that three only can with propriety be classed under that term: the *berat*, or bright white spot; the *boak*, or dull white spot, and the *tsorat*, or *venom*, of which there appear to have been two species, one a *berat lebena*, or bright white berat; the other, *berat checa*, or dusky berat. These two latter varieties spread very rapidly, whilst the two former were slow in their growth, and were not regarded as contagious by the Jewish lawgiver. Several other varieties of sore are mentioned both in the Scriptures and in the Rabbinical writings, but these characters were such as not to give rise to any suspicion of leprous taint. Amongst these were the *siat*, or herpes; *saphal* (*psoriasis*) *shecin*, and *mecutash*, corresponding respectively to *furunculus* and *anthrax*. The early Greek writers classed the simple forms of *berat* and *boak* under the title of *lepra alphos*, at the same time giving the names of *lepra leuce*, and *lepra melaina*, to the two forms of *tsorat*, namely, the *berat lebena*, and *bera checa*. They made, however, one most confusing error by adopting the term *tsora* or *psora*, from the Semitic languages, and making it a generic term for a class of diseases much milder than those which it originally included. In Hippocrates, a distinction is drawn between *lepra* and *leuce*, the former of which he declares to be much milder than the latter; the *leuce* is termed by him the Phœnician malady, being met with, as he asserts, principally on the coasts of Syria. Actuarius indeed placed *lepra* between *elephantiasis* and *psora*. "Lepra is a less violent disease than elephantiasis, but more severe than psora, and *psora* still more so than the lichens. *Lepra* penetrates deep, forms circular eruptions, and fungous excrescences, and throws off scales, from which it derives its name; while psora is more superficial, assumes indeterminate shapes, and only throws off furfuraceous corpuscles." Celsus, in the Augustan age, classes leprosy under the title of *vitiligo*, of which he says there are three species. "*Alphos*, when the colour is dull white, the surface rough and broken; the patches are generally large, and creep over the entire body, with a few uneven spaces between them. *Melaina* is only a variety of this, differing from it in the colour of the patches, but in all other respects quite the same. *Leuce* has a certain resemblance to *alphos*, but is of a more brilliant white colour, and eats deeper into the flesh. The hair upon it is white like wool. The *lepra alphos* and *melaina* appear and disappear, but the *lepra leuce* is exceedingly persistent. In elephantiasis the whole system is affected even to the bones; the surface of the body is covered with thick spots and swellings, at first of a ruddy hue, but afterwards changing to a dull dusky red. The skin becomes immensely thick, especially about the feet and ankles. In many chronic cases, the fingers and toes become buried in the diseased mass." The descriptions of later medical writers have added little further of interest to this account. The Jewish writers, who regarded leprosy as a special scourge from heaven, made no efforts to investigate the physical conditions of its origin and progress. Few pagan physicians attributed its primary development to the Hebrew nation, and it was reserved for the early votaries of Christianity to attribute its introduction into Europe to the miserable and persecuted remnants of the once chosen people. An assertion had indeed been made by Manetho, and adopted from him by Tacitus and Justin, that the leprosy had been the cause of the expulsion of the Jews from Egypt. Josephus, in his treatise against Apion, has ably refuted this opinion, though there is nevertheless, much probability that the leprosy became developed amongst the Jews during their captivity under Pharoah, owing to the insufficiency of food, and severe labour under a burning sky. The banks of the Nile were regarded by Prosper Alpinus as the home of leprosy, and Niebuhr has demonstrated its existence there at present in a very malignant form. Lucretius limits the disease of elephantiasis to the banks of the Nile.

> Est elephas morbus qui propter flumina Nili
> Gignitur Ægypti in medio, *neque præterea usquam.*
> De R. N. l. VI.

Quintus Severus, Macer, Pliny, and Marcellus Empiricus, all give us the same account. They tell us that this malady often attacked the very kings themselves, who resorted to human sacrifices in order to banish it. The history of Naaman shows us that the leprosy then existed in Syria and Damascus, and that the waters of the Jordan were considered to have those specific virtues which the inhabitants still attribute to them. In the time of Ctesias and Herodotus, leprosy prevailed to a great extent amongst the ancient inhabitants of Persia. All persons affected with it were at once excluded from society, and Plutarch tells us with surprise, that Artaxerxes did not divorce his wife Alossa, although her entire frame was covered with a leprosy. In India it seems to have committed great ravages at a very early period, and still causes immense havoc on the shores of Cochin China, Sumatra, and Borneo. The characters of this disease, as given by the writers of the fifth and sixth centuries of the Christian era, are too Protean and uncertain, to be limited to any one disease, or even class of diseases. As late as the time of Avicenna, there was a complete confusion of the terms lepra and elephantiasis. Even Richard Mead, writing in the year 1720, falls into the same error.

The Elephantiasis Græcorum, which, as we have seen, was so early confounded with the Jewish leprosy, was probably imported into Western Europe about the period of the First Crusade. How rapidly it spread we may infer from the fact, that there were more than two thousand *leper houses* (*mesellaria*) in France, about the year 1320, and Mathew Paris asserts that in his time there were nineteen thousand in the whole of Christendom. The unhappy inmates of these asylums were prevented by the most rigorous enactments from any intercourse with their fellow-citizens. No instances of cure are recorded, save those in the ecclesiastical writers, which are exceedingly vague. The lepers wore a peculiar dress, were obliged to give notice of their approach by a bell or rattle, and were not allowed to enter any market, or place where food was exposed for sale. Their property fell to the next heir, for the leper was regarded as civilly dead; with respect to his political rights, he was regarded as *capite deminutus*, in the language of the Roman jurists.

The vast establishments in which the lepers were confined, were supported by large ecclesiastical endowments, as well as by forced contributions of the surrounding inhabitants. In many cases the unfortunate districts drained by excessive taxation, and harassed by intestine war, were unable to meet these heavy demands, and the results of this default were most appalling. In several instances the lepers broke out into revolt, and were assisted by the Jews, who often in those barbarous times were confined with them in the same disgusting prison, upon the most trifling pretexts.—(Muratori Antiq. Ital. t. i.)

In the fifteenth century the tubercular elephantiasis seems to have been declining in Western Europe, and after the sixteenth it had become extremely rare. It still remains in Greece, and in the Crimea. I have seen, within the last year, a sailor from the Island of Corfu, who presented all the symptoms of the Greek elephantiasis in its early stage.

The endemic leprosy of the Hebrews seems to have abandoned them about the period of their final dispersion. I can find no mention of anything that can justly be referred to it, after the revolt of Bar-cochab, in the reign of Hadrian. At the present time, and perhaps in the middle ages also, they seem to have not suffered more from cutaneous afflictions than their Christian neighbours.

An intelligent German physician with whom I have corresponded tells me, that leprosy is exceedingly rare amongst the Continental Jews, and that such forms of it as are met with in Poland and Hungary were probably derived from intercourse with the Sclavonic races.

DUBLIN PATHOLOGICAL SOCIETY.

The Society held its last meeting for the Session on Saturday, April 28, when, after the usual business was transacted, the President, Mr. Adams, said:—

As this is the last day of meeting of this Society for the present session, it now devolves on me to report to the members and class of students here assembled, the decision of the Council relative to the essays which have been laid before it, on the subject proposed for the prize, "the Injuries, Diseases, and Malformations of the Spinal Column and Medulla Spinalis."

While it has been the privilege of each preceding President, at the close of the session, to call down from the benches before him some happy student, who had attained the first place among the prize essayists, and to hold him up before the members and his fellows, as an object well worthy of praise and of reward, mine, on the contrary, on the present occasion, I regret to say, must be confined to the barren office merely to announce that the Council, after much individual deliberation and consultation with each other, have come to the conclusion, that, although one or two of those essays were not devoid of some merit, *not one of the four presented this year could be considered worthy of the gold or silver medal.*

That such should have been the result, considering the large class of pupils which attended this winter, may well be considered a matter of surprise. While reflecting upon the subject, with a view of explaining how it has happened that the essays this year were found much inferior to those of the preceding sessions, an observation, made by some of the students themselves, has been suggested, to the following effect:— That the most advanced and best qualified among the students were too much intent upon obtaining their degrees to permit themselves to be drawn aside by any other object; and considered that to write an essay, with a view of obtaining a prize, should engross too much of their time; their main object being, as speedily as possible, to qualify and obtain appointments, and then commit themselves to the stream flowing eastwards.

And here I might cease, did I not think it well to warn future essayists, who may be ambitious to obtain the prize medals of this Society, that (if I rightly interpret the general feeling of the present Council) they are all willing to make every allowance for certain necessary shortcomings in students of only three or four years' standing. I also feel persuaded that the members of Council are, and always shall be too good anatomists and physiologists to expect to find "old men's heads on young men's shoulders;" still it will be expected that, in the future essays, proofs shall be given of the writer having received a good *general* education; the style may be unadorned, but it must *be correct* in every respect. It cannot be expected that the student shall be in advance of the day as to his pathological anatomy, much less so as to his suggestions on medical and surgical treatment, but we think when he composes an essay, as, for example, on the spine, with a view to obtain the gold medal of this Society, the information the student has to communicate should be written up to the very day of presentation. It may be more or less of a compilation (as concise as it can be), but it *must* be derived not merely from what is to be found in the *mature* editions of medical and surgical dictionaries, or in the abstracts of lectures of an old date. Now pathological societies exist in every city (thanks to the example set by Dublin in 1839, and specially to our two secretaries, Drs. Stokes and Smith, the originators of it), and the writer of a prize essay should, I think, take the trouble of searching the modern reports and published transactions of all such societies, as well as the catalogues of pathological collections, and the shelves of museums, and glean from these what is useful and to the point.

As to the symptoms and treatment, he must cull his information from observations made by *himself*, and from *his own notes* taken at the bedside of the patient, as well as under the instruction of the clinical physician and surgeon. It is, in my opinion, by such a right use of his time and exercise of his intellectual faculties, that the student shall lay the foundation of sound professional knowledge, as well as learn how to use it; and whether his object be to obtain a prize medal for his compositions, or favour with his own profession and the public, he can adopt no safer nor surer course.

We all felt sorry for the pain our decision must have inflicted on the unsuccessful candidates, but we believe that if the disappointment be taken in a proper spirit, and the true causes of it be sought for and made out, the result may prove ultimately beneficial rather than grievous, and may suggest to those who now feel disappointed, the truth of our poet's line—

> "That oft from apparent ills our blessings rise."

SELECTIONS FROM BRITISH AND FOREIGN JOURNALS, &c.

Memoir on Excision of the Head of the Humerus by a new Method of Operating.

BY M. BAUDENS.

[Read before the Academie des Sciences, Feb. 26, 1855.]

[The following memoir, independent of its intrinsic merits, will prove of unusual interest at the present time when gun-shot wounds are engaging so much of the attention of the medical world.]

M. Baudens insists on the duty of endeavouring to enlarge the sphere of conservative surgery, and to seek to substitute excision for amputation, the *ultima ratio.* This object he has always had in view. In 1836, he announced in his "Clinique on Gun-shot Wounds," that "excision should be the rule, and amputation the exception, in cases of comminuted fracture of the upper extremities." "Since the additional observations made on the hundreds of wounded admitted into Val de Grace, in February and June, 1848," adds M. Baudens, "we are able to go farther, and to prove that the majority of fractures of the leg, the result of gun-shots, may be preserved from amputation by removing the splinters, and by the application of ice and of our fracture apparatus." Conservative surgery is not merely limited to the avoidance of mutilations, it diminishes the mortality (*son necrologe est moins chargè que celui de l'amputation*).

The advantages claimed for excision by M. Baudens are, that it produces less shock, leaves a less extensive surface for traumatic inflammation, and is more likely to be followed by speedy union.

M. Baudens has employed excision of the head of the humerus in preference to amputation at the shoulder-joint, with the gratifying result of thirteen recoveries and but one death; hence he feels authorized to reverse an established rule, and to say that "*excision, when a ball has broken the head of the humerus, ought to be the rule, and amputation the exception.*"

This operation dates back more than a century, having being first performed by Thomas, a surgeon of Pezenas (Languedoc), in 1740, for necrosis of the head of the humerus. Subsequently, Boucher, in a memoir on gun-shot wounds, and after him, Percy and Larrey, showed that by removing the shattered head of the humerus, the arm might be saved. This operation has been most successfully performed by White, Vigarous, Moreau, father and son, &c., in cases of disease.

According to M. Baudens, the real value of the operation has not as yet been fully decided. Larrey, he says, thinks that the use of the arm is greatly impaired, and that the subjects of this operation are unable to raise the arm on the scapula.*

In 1854, M. Gimelle gave the following opinion, in a Report to the Academy: "Resection of the head of the humerus reduces the arm to impotence, it falls like the pendulum of a clock, and is often of more annoyance than use." M. Sedillot gives the same opinion.—(Mèdecine Opèratoire, p. 497.) From the results of M. Baudens' experience, he disagrees entirely with these opinions. "On all occasions," he says, "in which excision is limited to the head of the humerus, we have always found the motions of the arm to be restored; but the new scapulo-humeral articulation becomes a ginglymoid instea of an arthrodial joint."

I. *Means of obtaining a New Articulation.*

In order to obtain a new articulation, two indications must be rigorously carried out. 1. To keep the humerus in *immediate contact* with the glenoid cavity. 2. To take as much care as possible of the muscles and nerves of the shoulder. Hence, M. Baudens says, that of the two methods recommended of performing this operation, viz., by flap or single incision, he has no hesitation in selecting the latter. He objects, therefore, to the operation as performed by Moreau, Manne, Sebatier, Bent (of Newcastle), Morel, Syme, &c., all of whom employed modifications of the flap operation. The method by single incision was that originally performed by White. The difficulties of this mode of procedure, he admits, are greater. These difficulties are stated to be two-fold: the first, arising from the energetic contractions of the deltoid muscle, which render it difficult to expose the head of the bone; the second, from the head of the bone being drawn high up into the coraco-acromial vault by the contractions of the scapular muscles. These muscular contractions are the "gordian knot" of the operation. To overcome them, says M. Baudens, the tuberosities are by rotation to be alternately brought into the centre of the incision, and the muscles divided, and with them the capsule which is confounded with their insertions, by which an opening is made sufficiently large to give exit to the head of the humerus. These peculiarities which, according to the author, were not previously known, led M.

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* We scarcely think M. Baudens has done justice to Larrey in this matter. Larrey, we are of opinion, has fully established the propriety of excising the head of the humerus when practicable. In his work on "Military Surgery," he says, "I have had the good fortune on ten different occasions to supersede the necessity for amputation at the shoulder, by the complete and immediate extraction of the head of the humerus, or its splinters, without delay; seven were cured, three died." "In some the arm became anchylosed to the shoulder, and in others an artificial joint, allowing of motion, was formed."—*Translator.*

Baudens, in 1833, to modify materially the method of White. Instead of making the incision externally (or nearer the acromion), as White did, M. Baudens makes it *internally*, for three reasons: first, because the head of the bone is here more superficial; secondly, because the incision can be prolonged as high up as is necessary to expose all the bone; whilst, thirdly, it enables the operator to come down at once upon the bicipital groove, and thus upon the muscles (capsular), the division of which forms the key to the whole proceeding. "The advice given by authors to cut the capsule first, and the four rotator muscles afterwards, is precisely the reverse of what ought to be done." The capsule need not be specially sought after; "all that is necessary is, to make the section of the muscles, at the same moment the capsule will be found to be largely opened; then the head of the humerus, which had been drawn up into the arch beneath the acromion and coracoid processes, and held there as if in a vice, immediately descends, and from that moment can easily be made to project through the opening in the capsule."

Mode of operating, as performed by M. Baudens. The operation is divisible into four stages or periods:—

First Stage.—The arm being everted, the point of a small amputating knife is to be passed directly down to the head of the bone, on the outside of the coronoid process, and carried downwards for about five inches, keeping the knife in contact with the bone.

Second Stage.—If necessary, cut a few fibres of the deltoid transversely, without wounding the skin; open up the bicipital groove, and cut across the tendon of the biceps.

Third Stage.—By rotating the arm alternately inwards and outwards, we are able to expose first, the greater, then the lesser tuberosity, and freely to cut across the muscles inserted into them.

Fourth Stage.—The capsule having been thus opened, the elbow is to be carried backwards and upwards, so as to luxate the head of the humerus, and make it protrude through the wound; then, with the saw, remove the bone, sparing, as much as possible, the posterior attachment of the capsule and the periosteum. [M. Baudens attaches much importance to this point, in consequence of the "belles decouvertes" of M. Flourens, on the regeneration of bone by the periosteum.]

Fifth Stage.—Tie the vessels, cover the extremity of the humerus with the preserved periosteum, as with a hood, keep it in direct contact with the glenoid cavity by propping up the elbow with a bandage, and endeavour to obtain union of the soft parts, except at the lower angle of the wound, where a tent is to be inserted to allow matter to escape.

II. *Within what limits is the incision to be confined?*

M. Baudens enters at length into this question. The operation admits of several modifications, but the grand rule is to save as much bone as possible. Thus, 1. When the head of the bone is but partially injured, he has been able to remove the half only. This, he says, has never been previously done. 2. All the head may require to be removed; but it is very important not to encroach on the anatomical neck, and, at all events, to take care of the attachments of the capsule posteriorly. 3. If the anatomical neck of the humerus must be divided, the insertions of the muscles are to be preserved as much as possible. 4. In one case, where the humerus was greatly comminuted, I removed, says M. Baudens, the humerus below the insertion of the deltoid. "Here, the bone being connected by soft parts only, was deprived of the movements of the scapula, but the motions of the forearm and hand were preserved intact. Even here, the result was far more satisfactory (*magnifique*) than is ever obtained by amputation at the shoulder joint." 5. In one case, M. Baudens removed, with success, the head of the humerus, the glenoid cavity, the acromion process, and all the spine of the scapula.

III. *When the fracture of the head of the humerus extends downwards into the shaft* [split fracture], *is this a case for amputation?*

Larrey does not hesitate to answer in the affirmative. "Amputation," he says, "is in that case indispensable." [Cl. Chirurg. Tome v. p. 183.] This opinion, which is likewise that of many other surgeons, is not the opinion of M. Baudens. "In four cases," he says, "we were content to remove only the head of the humerus, without minding the fissures which ran, more or less, down the shaft of the bone into the medullary canal, and recovery took place just as if these fissures had never existed." M. Baudens adds, that he has often seen, in amputation for gun-shot wounds, longitudinal fractures in the bone which formed the stump, from which no unpleasant consequences resulted. "The fissures got well as simple fractures do."

In amputations of the thigh for comminuted fractures, this is a point of much importance; as the mortality is much influenced by the proximity of the amputation to the trunk. M. Baudens says, the limb should be removed close to the fracture; and adds, "that he has more than thirty times carried this rule into practice, and never regretted leaving a fissure in the osseous tissue." Longitudinal fractures, he adds, are so frequent as the result of gun-shot wounds, "that it would be very difficult to avoid them in amputating, as we are often in ignorance of their precise extent, but fortunately they remain unobserved as to their results."*

IV. *Is it absolutely necessary to excise the head of the humerus when it has been broken by a ball?*

M. Baudens says, from his experience, the operation is *always requisite*. When this is not done we learn that "one of three results are observed:—1. Death from purulent infection; 2. the necessity for secondary excision; or 3. the patient survives with anchylosis, or fistulous openings, in a state of suffering and peril, the issue of which is uncertain."

V. *Is immediate excision to be preferred to secondary excision?*

M. Baudens furnishes the following statistics:—

"In twenty-six cases the head of the humerus was thus injured. In eleven excision was *immediately* performed, ten recovered, one died; in fifteen the operation was deferred in the hope that, because their wounds perhaps were less severe, they might recover without an operation. Of these fifteen, eight died of purulent infection; three underwent secondary excision (all of whom recovered), and four survived with fistulous openings.

"Hence, we see the success of three secondary excisions was dearly bought, since from not having operated at once, eight of the wounded died of purulent infection."

The remainder of the memoir is occupied with illustrative cases which are of extreme interest, and which corroborate the principles laid down in the preceding pages.

B.

Account of a Case in which Death was occasioned by a Fish-bone penetrating the Aorta through the Œsophagus. By WILLIAM COLLES, Surgeon to Steevens' Hospital.

John Bryan, æt. 56, a labourer, was admitted into Steevens' Hospital, March 30th, 1855. About three or four o'clock the day previous to his admission, while eating, he swallowed a fish-bone, which he states he felt cutting him very much at the time "in his chest;" the cutting pain being increased exceedingly by the act of swallowing. Immediately after he commenced to spit up large quantities of blood of a dark colour, which, however, soon changed its character, being bright red. He did not apply for admission into hospital till twelve o'clock the next day. He then complained of acute pain in his chest, and of great weakness. He had a blanched appearance, and a decidedly hæmorrhagic pulse. Immediately after his admission he vomited up a fish-bone about an inch long, of a very irregular shape—the pre-operculum of a herring; it had a great number of sharp points and cutting edges. He continued to vomit up a good deal of blood throughout the day, but not so much as at first; the quantity gradually diminishing until nine o'clock the same evening, when he died.

Post Mortem Appearances.—On opening the thorax, about three ounces of reddish-coloured serum were found in each pleural cavity, and about an ounce of fluid of similar appearance in the pericardium. The posterior mediastinum was filled with coagulated blood. Upon removing the œsophagus and slitting it up, there was seen upon its posterior wall an oblong irregular opening, about half an inch in length from above downwards: the opening corresponding with the termination of the descending portion of the arch of the aorta, through which there was a slit or tear exactly opposite to that in the œsophagus, but differing from it in being smaller and more irregular. Upon examining the abdomen, a large clot of blood was found in the stomach, and the small intestines were filled with a similar fluid.

Mr. Colles remarks, that of the cause of death here there can be no doubt, the opening through the œsophagus into the aorta having been evidently produced by the sharp rip of the fish-bone which had been displaced and rejected by vomiting some hours before death.

It proves how great an amount of force is exerted in the mere effort of swallowing, sufficient to cause such a cutting instrument as the edge of this bone presented to penetrate through the coats of the œsophagus and aorta. Had a probang been employed in this case, no doubt the cause of the injury would have been ascribed to its use; but I doubt that a probang is ever introduced with such force as to drive a foreign body through the firm structures that exist here when they are in a healthy state. —*Dublin Quarterly Journal.*

Neuroma of the Neck; Removal; Cure.—The following interesting case is related by M. Barrier of the Hotel Dieu, Lyons. "Upon the 3rd of June, 1854, Francoise Beaujeu, a woman 31 years of age, was admitted into the Hotel Dieu at Lyons; she was of lymphatic temperament, had had formerly scrofulous abscess in the neck, and although of a delicate constitution had not ever been very seriously ill. For years before this, she had, after exposure to cold, suffered from a severe pain in the left arm, principally during the night. This pain was at first undefined, and did not prevent free movement of the arm; it soon, however, became much worse, the arm got thinner, and to keep it warm she was obliged to wrap it in cotton. Six months ago she accidentally discovered a tumour painful to the touch upon the left side of her neck. The physician whom she consulted told her this tumour was the cause of the pain in her arm, and advised its removal; for this purpose she entered the hospital. The left arm at first sight appeared healthy, but a little thinner than the right; the slightest movement caused pain. At the upper part of the posterior inferior triangle of the neck, there existed a tumour about the size of a walnut, hard, not adherent to the skin, but slightly moveable; pressure caused acute pain, which was propagated along the trajet of the median nerve, through the arm, fore-arm, and in the hand to the three first fingers; this pain was accompanied by a prickling sensation, and numbness. M. Barrier, having diagnosed a neuroma in intimate relation with the brachial plexus, determined upon the removal of the tumour. Upon the 11th of July the operation was performed.

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* This opinion, we think, should be received with some reserve. In a case of comminuted fracture near the centre of the tibia, we have seen a fissure to extend up into the knee joint, which, becoming inflamed and subsequently disorganized, rendered amputation of the thigh necessary. Had the injury been so severe as to require amputation, in the first instance, according to M. Baudens' rule it should have been performed just above the seat of fracture, and in that case, secondary amputation would have been required for the subsequent disorganization of the knee joint. The case alluded to was treated in the Richmond Hospital by Dr. Hutton.—TR.

The patient being rendered unconscious by the inhalation of ether, was laid upon her back, the body and head inclined to the right side; an incision was then made parallel to the sterno-mastoid muscle, over the most projecting part of the tumour; the external jugular vein, here met with, was drawn to the inside; a small nerve which crossed the front of the tumour was cut at its upper part, then by careful dissection the tumour was separated from the nervous trunks to which it was attached. It was very intimately attached to one trunk behind, probably the median. As soon as the nervous attachments were separated, it was an easy matter to detach the tumour from the fibro-cellular membrane which enclosed it. The hæmorrhage was inconsiderable; two ligatures, and some charpie, pressed into the wound, sufficed to restrain it.

Examination of the Tumour.—It was found of cartilaginous hardness, reddish in the centre, shining and smooth on the surface. The microscope discovered in it nothing but the elements of fibro-plastic and cellular structure. Upon the 12th of July, there was some fever; the head was inclined to the right side, and could not be moved without pain. The thumb was almost without sensation. Upon the 14th, there was considerable suppuration; pus was found running down from the wound along the course of the brachial plexus; during the following days the suppuration lessened. The pains through the arm, however, continued. Upon the 28th the wound was healed, all the movements of the neck and arm could be performed with ease, slight numbness alone remained in the thumb.

This case of neuroma is chiefly remarkable from the seat of the tumour. These tumours occasion almost always severe pain. In this case the pains were caused more by the radiating as it were of the irritation along the nerves than by mechanical pressure. The operation was a delicate one; much care was necessary to avoid injuring the neighbouring nervous trunks; this, however, was accomplished by the operator. After the operation, considerable apprehension was excited by the continuance of very severe pain for some days, accompanied by a tetanic rigidity of the muscles of the neck, which made the slightest movement extremely painful. These symptoms, however, disappeared by degrees, the wound cicatrized, and the only remains of the disease which the patient complained of, a month after leaving the hospital, was a slight numbness of the left wrist."—*Revue Medicale.*

Physiological Action of Veratrine.—The following conclusions have been arrived at by MM. Leblanc and Faivre, after numerous experiments upon this subject. Veratrine exercises three distinct actions upon the animal economy, which actions are in proportion to the quantity of the medicine administered.

1st.—A well marked action on the digestive tube.

2nd.—An action upon the organs of circulation and respiration.

3rd.—An action upon the nervous system, and upon the muscles of organic life.

In the First Period.—Veratrine acts upon the digestive tube, increasing its sensibility, contractility, and secretions.

The exaltation of sensibility is evinced by the access of colic, the violence of which is in proportion to the quantity of the drug; tenesmus too is often much felt.

In addition to these pains, there is joined the phenomena of the muscular contraction of the intestines, the peristaltic motions seem greatly accelerated. M. Magendie has remarked this phenomenon in dogs, and we have often noticed it in frogs, under the influence of veratrine; the follicular secretion of the intestines, and that of the salivary glands, are augmented. We have often been struck with the rapidity with which the saliva flows after the administration of veratrine, and the continuation of the flow for a considerable period.

When the drug is allowed to lie in direct contact with the mucous membrane, appreciable alterations seem to take place; we have found under these circumstances, in the stomach and small intestines, circumscribed red patches, distinct from one another, and half an inch in diameter.

Second Period.—The prostration of strength and failing of the circulation mark the second period. Every time that we have examined the state of the circulation, before and after the administration of veratrine, we have found it produce diminution of the pulse, and often its irregularity. But this diminution, very marked and continuous with certain doses, ceases when the dose becomes more considerable, and the pulse gradually becomes fuller and quicker. During this period of prostration, the dogs who were the subject of experiment looked greatly exhausted, and generally lay down.

Third Period.—When the doses of veratrine become larger still, the symptoms of tetanus are not long in showing themselves. Both the fore and hind limbs become stiff and rigid, the muscles of the thorax and abdomen, too, are contracted, and the respiration becomes difficult and laborious; the trismus of the lower jaw was an obstacle to the free purification of the blood, and asphyxia became soon very marked. An augmentation of sensibility always accompanied the tetanic symptoms.

The effects produced by veratrine do not always follow accurately the order we have laid down, nor do the three periods follow one another with perfect regularity. Thus, the action upon the digestive apparatus may be more or less marked, and may be continued during the period of depression, or even of excitation; and the phenomenon of the depression of the circulation and tetanic convulsion may be variable both in intensity and duration.—*Gazette Medicale.*

Incision of the Vulva, as a Means to prevent Laceration of the Perinæum during Delivery. By M. Carpentier.—Obs. 1.—The subject, a patient in labour with her first child, had had strong pains for a long time; the head had appeared at the vulva; it remained there two hours, in spite of the intensity of the expulsive efforts. The author, without delay, made an incision, not in the raphe, but at the side of the vulva, immediately after which, a strong contraction terminated the labour.

Obs. 2.—In this case, the difficulty of the labour made it necessary to employ the forceps, which was applied without difficulty; but when the head of the child appeared at the external orifice, it became evident that the labour could not be concluded without a considerable laceration of the perinæum; taking advantage of a severe pain, an incision was made through the vulva, and the child was extracted without difficulty.

These two facts, if they do not prove the absolute necessity, at least show the usefulness of the operation. It is incontestible, that in many first labours, lacerations of perinæum take place to a considerable extent. It is certain, too, that in spite of every precaution taken to protect the perinæum, we observe sometimes rents occur almost to the rectum. The incision of the vulva, practised in the case of narrowing of the orifice, has the advantage of replacing a rent made by violence, and, as it were, blindly, by a regulated and defined operation.—*Gazette Medicale.*

Employment of the Alkaline Carbonates in the Treatment of the Membranous Angina. By M. Marchal de Calvi.—The author advocates the employment of alkalies in this sometimes most intractable disease, and cites cases treated by the bicarbonate of soda, in which the recovery was rapid, immediately following its administration. In the first case, the mucous membrane, at the back of the throat, was very red and œdematous; the mucous membrane, too, covering the palate and tonsils, was covered with stripes and patches of false membrane. This exudation was beneath the epithelium, for it could not be scraped off with the nail. Deglutition was performed with considerable pain. Twelve leeches were first applied to combat the inflammation, and three drachms of bicarbonate of soda were ordered to be divided into twelve packets, one to be taken every half-hour, in a spoonful of water. Upon returning, after an absence of four hours, he found that the leeches had drawn a large quantity of blood, which was decidedly less plastic than natural. Upon examining the throat, the false membrane was found to have disappeared entirely. This, the author attributes to the administration of the bicarbonate of soda, whose action he thus explains. Its first or chief action is to render the blood less plastic. It is with this object in view that the medicine is prescribed; but there seems to be another mode of action in this peculiar disease, which M. Suresure has supposed likely to exist, viz. a local action; which may account more satisfactorily for its rapid action in the case just recorded.—*Gazette Medicale.*

Sugar secreted by the Liver.—This function of the liver, pointed out some time ago by M. Bernard, is now called into question by M. Fiquier, Assistant Professor at the School of Pharmacy of Paris. The discussion is taking place before the Academy of Medicine, and has given rise to several clever papers. We may add that Lehmann, of Leipzig, has lately made experiments which would tend to strengthen M. Bernard's views respecting the glucogenic functions of the liver.—*Lancet.*

DUBLIN: PUBLISHED BY W. B. KELLY,

8, Grafton-street.

LONDON: S. HIGHLEY, 32, Fleet-street.

EDINBURGH: MACLACHLAN & STEWART.

May 15, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.

SENT FREE BY POST.

Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 9.—Vol. II. JUNE 1, 1855. Price 5d.

WHITWORTH AND HARDWICKE HOSPITALS.

Increased Action of the Heart and Arteries of the Neck; with Enlargement of the Thyroid Gland, and Prominence of the Eyeballs; Dropsy, Effects of Digitaline.

BY JOHN T. BANKS, M.D.,
KING'S PROFESSOR OF PHYSIC; PHYSICIAN TO THE HOSPITALS.

The subject of this case, a woman, æt. 30, was admitted into Whitworth Hospital, January 25, 1855. Her health had been good up to the age of 15, and no hereditary taint was discoverable. About the age of puberty she suffered much mental disquietude, from which she has never since been altogether exempt. She does not remember the exact period when the catamenial function was established; it had always been irregular, and for the last year and half had ceased altogether, having been suddenly arrested in the midst of a period. She has always been nervous and subject to palpitations of the heart. Every winter for the last few years has had bronchitis; some time since she suffered from a fit of violent vomiting and straining, and after this she perceived that her neck was swelled, and she felt a sensation of throbbing in it. Of late she has been much distressed by palpitations and pulsation in the neck, and a feeling as if she were being choked by something drawn tightly round her throat; for the last ten nights she has been almost sleepless, and utterly unable to lie down.

On admission she presented the following appearance:—Wild agitated expression of countenance; dusky hue of skin; eyes unnaturally prominent, staring, and brilliant; evident enlargement of the thyroid gland, more particularly of the right lobe; violent throbbing of the vessels of the neck, which were considerably augmented in size; one large superficial vein crossed the trachea.

The thyroid, permanently enlarged, becomes much more turgid on the occurrence of palpitation of the heart, or paroxysms of coughing; a purring thrill, a loud continuous venous murmur, and an interrupted arterial sound are present.

The area of precordial dulness is increased; the heart's action is tremulous and irregular in the extreme; a few unequal beats of extraordinary rapidity, and then a brief pause. No murmur was distinctly audible.

The pulse is small, feeble, and unequal, and so rapid as to render it almost impossible to calculate its frequency; the countenance indicates great suffering. She says her chief distress arises from inability to lie down, or to sleep quietly, from a "feel as if her heart was in her throat." She also complains of headache and frequent cough; during the fits of coughing, her urine passes away involuntarily. With the exception of bronchitic rales, nothing abnormal was found by auscultation of the lungs. The heart's sounds were more extensively audible than is usual in health.

From the date of admission, January 25 to February 6th, no marked change in condition of patient; at the latter date, œdema of the lower extremities and a slight puffiness about the eyes, were observed. Greater respiratory distress;

restlessness and mental disquietude. The size of the thyroid is rather greater than when first seen; position has a remarkable effect on the pulsation; on assuming the recumbent posture, which always causes dyspnœa, the throbbing of the vessels visibly diminishes, and the murmurs become almost inaudible. The urine is of a dark smokey colour, albuminous, and depositing a sediment which, on examination, was found to consist of broken down blood globules, sp. gr. 1.017. The heart's sounds more regular.

From this time the patient rapidly declined in strength; the œdema extended almost over the whole body; the cellular tissue of the back was the seat of extensive effusion; inability to sit up from weakness, and she says from the weight of her head, and giddiness. Still the pulse remains more regular (96). The character of the urine unchanged.

For the last week of life intense bronchitic rales were heard, and there was an abundant expectoration of a bloody fluid, not viscid.

It should have been remarked that the vision was perfect up to the close of life. There never was the slightest inflammatory affection of the eyes. Death, which occurred on the 7th March, was rather sudden. She had been speaking a few minutes before, and so free from struggle were her last moments, that those near her did not know exactly the moment of her death.

The morbid appearances presented on examination were in many respects interesting.

The thyroid gland, enlarged to four or five times its natural size, was found to cover, to a considerable extent, the front of the trachea. The right lobe was larger than the left, the thyroid veins were remarkably dilated.

The gland was dense, very solid to the feel, and lobulated. A section of different parts disclosed the existence of numerous cysts, containing a yellow fluid like honey. The contents of some of the cysts were dark coloured, and resembled coagulated blood. The microscopic appearances were similar to those observed and figured by Rokitanski in ordinary enlargement of the thyroid. The jugular veins were enlarged; the bronchial glands were found of an unusually large size; the heart was enlarged generally and the cavities dilated, but not to any considerable extent.

The heart was as large as that of an ordinary man, the subject being a woman under the middle size; the valves were free from disease, with the exception of slight thickening of the anterior edge of the mitral valve.

The lungs were highly congested, and the bronchial membrane bore the marks of intense inflammation.

The liver appeared as if in the earliest stage of cirrhosis; the spleen large and congested.

The brain softer than natural; the lining membrane of the ventricles much thicker than usual.

The kidneys had undergone the changes usually observed in the early stage of Bright's disease.

The case reported presents to our notice an example of a disease which is not very frequently met with, even by physicians enjoying extensive opportunities for observation.

Comparatively rare as it is to encounter the disease, it is still more rare to have an opportunity of investigating its morbid anatomy.

Few are the dissections recorded to which we can refer in the hope of arriving at a satisfactory conclusion as to the pathology of this most obscure affection.

That the disease, with all its characteristic phenomena, may exist without organic lesion of the heart or other morbid condition, tending of necessity to shorten life, is confirmed by the observations which have from time to time been published.

In the woman who was the subject of the present notice, violent palpitations of the heart had existed for many years, with irregularities of the uterine functions, and she had, moreover, suffered from the effects of violent mental emotion. This is the history of some of the recorded cases of the disease. Functional derangement of the heart then seems to be the *point de départ* in the greater number of instances of this disease. Nervous and hysterical females, however, are not the only persons who are found to labour under this disease. Men, though by no means so frequently, and females of advanced age, have also been found amongst the victims of the malady. We cannot, therefore, assign to abnormal states of the uterine function, an important part in the production of the disease. It has been noted in some cases that the catamenia were *perfectly regular*.

It may be observed, regarding one of the most remarkable phenomena of the disease, namely, the prominence of the eyes, that it has been observed to occur suddenly. In the present case the woman was unable to inform us as to the time when her eyes were first noticed to have acquired this remarkable character; probably at the period when the thyroid gland became enlarged. To the learned President of the Pathological Society, Mr. Adams, we are indebted for the observation of the fact of the eyes having become prominent *suddenly* after a violent fit of coughing. The scanty materials from which to establish the pathology of this disease have been already alluded to. It is of value then to place on record every necroscopic examination, even though little, if anything, be contributed in the way of foundation, upon which to erect a theory as to the efficient cause of this most obscure disease. *The first recorded case with which the pathological appearances are connected,* has been contributed by Sir Henry Marsh, and, as such, is eminently deserving of particular notice. Many years since, when Sir H. Marsh presented to the Pathological Society the heart and thyroid gland of a person who had laboured under this disease, he observed that he had seen previously other cases which presented the like phenomena, viz., "remarkable engorgement of the veins, particularly those of the neck; rapid, violent, and irregular action of the heart; and these in every instance coexisting with enlargement and swelling of the thyroid gland. In the majority of cases, there was a remarkable prominence and protrusion of the eye-balls, so as to give to the group of symptoms, by which the disease is characterized, a very striking feature." In the heart exhibited to the Society the following appearances were observed:—"The left auricle was enormously dilated. The dimensions of the right auricle were also considerably increased, though not to such an extent as those of the left, and the muscular fibres of its walls were slightly hypertrophied. The left ventricle was dilated and hypertrophied, but not to a remarkable degree: along the margin of the mitral valve were depositions beneath the lining membrane; in the recent state they resembled depositions of granular fat, and their effect was to thicken the edges of the valves, and of course interfere with the free discharge of their functions. The disease appeared to be restricted to the auriculo-ventricular valves. "The thyroid gland was irregularly lobulated, and the lobes or cysts contained a considerable quantity of clear fluid. The external and internal jugular veins were very much dilated. The subject of this case was a tall person, and he had several times observed the disease in persons of tall stature."

Sir H. Marsh has also noted cases in which there was no abnormal cardiac sound, and in which he believed there was no valvular disease of the heart.

In Dr. Stokes's work on the "Diseases of the Heart," is to be found an account of the morbid appearances observed in a case of this disease by Professor R. W. Smith. Many points of resemblance exist between the pathological conditions in this case and Sir H. Marsh's. In both dilatation of the heart, to a great extent, existed.

Professor R. W. Smith informs us that in this case, the morbid appearances of which he has reported, and which was under the care of the late Dr. M'Dowel, in the Richmond Hospital, "no dilated veins could be seen ramifying on the surface of the neck." This contrasts remarkably with the case I have brought forward, in which the dilatation of the superficial veins formed so prominent a feature.

In the case under consideration, the enlargement and dilatation of the heart were inconsiderable, but the woman laboured under other diseases, which powerfully co-operated in bringing her life to a close before the heart had undergone those profound changes, which doubtless would have awaited it in the absence of the intercurrent renal and hepatic affections.

The presence of albuminuria in this case is worthy of notice, not having been observed, that I know of, in any previously reported case of this affection. For ample details of this disease, and for much valuable information derived from the observation of cases in his own practice, as well as from an analysis of all the recorded examples of the disease, the able work of Dr. Stokes may be advantageously consulted.

One observation of importance to the practical physician may here be introduced:—With a view to induce diuresis, digitaline was administered in this case; the preparation employed was the greyish white powder, the dose, the 75th of a grain, three times daily. On the third day, the action of the heart had become less rapid and more regular; no diuretic effect had been produced. It had been a point of much difficulty to determine, owing to the excessive rapidity and irregularity of the cardiac action, whether a murmur was present or not. The effect of the digitaline soon solved the doubt, and it became manifest that no abnormal sound existed; it was not deemed expedient, however, under the co-existing circumstances, to continue the use of the digitaline. The result of the administration of this therapeutic agent is confirmatory of the views of Professor Christison, who has observed, "that the two actions of digitalis, its diuretic and sedative actions, do not concur. It is very likely that they are even incompatible." I may state that I have, in some cases of dropsy, witnessed the good effects of digitaline as a powerful diuretic, and that I have given the drug in larger doses than those recommended by MM. Homolle and Quevenne, viz. the 75th of a grain. I have lately given the 60th of a grain as a dose, and I am now instituting a series of investigations upon its therapeutic powers. In renal dropsy, I anticipate good effects. In this disease we are often precluded from using the infusion of digitalis, the most certain of the preparations of digitalis, as a diuretic, from the excessive irritability of the stomach. So far as my observations go, I have not found the stomach intolerant of the digitaline, and the extreme minuteness of the dose renders it likely that it may be borne when digitalis would be inadmissible.

On the 10th of March I brought this case, with the *post mortem* appearances, under the notice of the Pathological Society, and Doctor Begbie, of Edinburgh, has since published, in the case-book of the *Edinburgh Medical and Surgical Journal*, a very interesting communication on the subject of this disease.

The conclusion which Dr. Begbie arrives at, viz., "that the true pathological character of the disease" has been pointed out by him, we humbly dissent from.

We cannot admit with Dr. Begbie, "that the point of departure from health is in the impoverished condition of the blood." That this state of spanæmia is competent to generate the complex disease spoken of here we are not inclined to concede. In some instances, the persons affected with this malady, so far from presenting the well-known signs of depraved blood, were actually of "florid complexion, and with every appearance of robust health."

Occasionally we find cases of this disease to occur in chlorotic females, in whom there is no organic disease, and in such cases the treatment directed to improve the blood exercises a most salutary influence.

Sir Henry Marsh found, in one case, the exhibition of carbonate of iron and hyosciamus very beneficial.

Doctor Stokes treated a case by anodynes, and subsequently by digitalis, with marked benefit. Cases of this disease are fairly divisible into two classes: in the first, there is no sign indicating the presence of organic disease; and in the second, the heart is often profoundly altered, with occasionally lesions of other important organs superadded.

In the first class, sedatives—digitalis probably the best, and in the event of the blood being poor, in red corpuscles, iron—constitute the remedial measures calculated to produce good effects. In the second class, all treatment, except mere palliative, proves abortive.

Fully impressed with the fact, that a host of diseases may spring from imperfect sanguification, I must repeat my conviction that the complex malady under consideration cannot be ranked among them.

Dr. Stokes says, "There are strong reasons for supposing that the disease is originally a neurosis of the heart, and probably of the cervical vessels." There is much of probability in this idea. I am satisfied that any hypothesis which attempted to explain the phenomena, solely by reference to the heart, would be unsatisfactory, for there cannot be a doubt from the tumultuous action of the cervical vessels, often disproportionate with the heart's action, but that they are, to a certain extent, under some powerful and independent influence.

STEEVENS' HOSPITAL.

Case of Rupture of the Bladder from Indirect Violence; Death in Eighty Hours.

BY S. G. WILMOT,

SURGEON TO THE HOSPITAL.

Christopher Callaghan, æt. 30, a railway porter, was admitted into No. 1 Ward, on Feb. 14th, suffering from peritonitis.

History.—He states that about eight o'clock on the previous evening, he was walking very fast to the terminus of the Great Southern and Western Railway, at King's-bridge, when his foot slipped on the pathway, which was covered with ice at the time. Having his hands in his coat pockets, he made a violent effort to save himself from falling, but in doing so the other foot slipped also, and he was thrown on his back with great violence to the ground. He wanted to make water at the time, and when he fell, he thought he felt something give away in the abdomen, and he was seized with such faintness as to be unable to rise from the ground, till two men came to his assistance. He was at once brought on a car to his lodgings, and put to bed, and (as his extremities and the surface of his body were cold) heat was applied. In a short time after this he was seized with a violent burning pain in the hypogastric region, and also a great desire to pass water, which he was unable to do till a catheter was introduced, and about four ounces of bloody urine were drawn off; this operation, and the application of turpentine fomentations to the abdomen, somewhat relieved him; but in about three hours the pain recurred; the catheter was again introduced and about two ounces of urine drawn off, the latter portion only being mixed with blood. He had also great thirst, and some sickness of stomach. Soon after he was attacked with the pain, he had to lie on the right side, with the knees drawn up as much as possible, and the thorax thrown downwards and forwards; by thus having the abdominal muscles relaxed he was comparatively easy. As soon as possible the next morning he was brought down to hospital, when he was admitted in the following condition:—Countenance anxious; features pinched, and the eyeballs sunk in the orbits; tongue moist, with a white fur down the centre, and around the edges, the remainder of the surface being of a bright red colour; respiration much hurried; pulse 120, hard and wiry; voice very weak; he was lying on the right side, with the knees drawn up to the abdomen; pressure over any part of the abdomen caused him great pain, but he was more particularly tender in either iliac region, as also in the hypogastric region over the bladder. There was considerable fulness of the abdomen, which yielded a dull sound on percussion. As he was complaining much of the wish to pass water, a catheter was introduced for him, and only about two ounces of urine passed away, which seemed perfectly normal. He was much relieved by the introduction of the catheter; he has violent thirst, and prefers cold water to anything else. He was ordered

℞ Calomelanos, gr. ii.
Opii gr. ¼. 3tiis horis.
Fotus terebinth. abdomini.

February 15th.—This morning seems much the same way; abdominal tenderness still unabated; he did not sleep during the night, but for a few hours previous to visit, slumbered a little. The pulse has not the same peculiar hard wiry feel it had on admission, but is soft and rather weak, being still 120. He was ordered a large blister over the abdomen, to rub in mercurial ointment, take the pills every hour, with the dose of opium increased. Thirst still very urgent. An injection was administered, which produced a copious evacuation; during the day he expressed himself tolerably easy, but the slightest motion of the body, or pressure on the abdomen, caused him very severe pain.

February 16th.—Slept some during the night, and expressed himself easy, and free from the burning pain he had. Gums seem a little soft and spongy; pulse 130, and very weak and compressible; other symptoms as on last report. During the day he was seized with vomiting, which was very violent, the ejected matter being seemingly a quantity of bile, diluted with the fluid he drank. Pulse became so quick as to be with difficulty counted, and very weak; he is evidently (though perfectly conscious) moribund. Stimulants, &c., were administered, but without avail, as he expired during the night.

Post Mortem Examination.—On opening the abdominal cavity, a quantity of fluid (which by its odour was at once distinguished to be urine) escaped; there was about twelve ounces of this in the peritoneal cavity; the intestines were glued together firmly by lymph, which, in some situations, was partly detached. The omentum was much inflamed and congested, and contracted very much under the great curvature of the stomach. The inflammation seemed general over the entire peritoneal surface. On raising the intestines out of the pelvis, the bladder was found quite contracted behind the pelvis; and in this situation lymph was effused in much greater quantities than in any other portion of the peritoneum. On the right side, and on a level with the brim of the pelvis. there was a large rent in the peritoneum, commencing immediately external to the obliterated hypogastric artery, and extending from that point transversely outwards for about three inches. In looking to the bottom of the wound, the vas deferens was to be observed going down to the vesiculæ seminales, and on passing the finger downwards, it immediately entered the bladder through a rupture in its fundus of about two inches. It did not seem that any urine was extravasated in the cellular tissue beneath the peritoneum.

Immediately around the rent in the peritoneum, the inflammation seemed to have been much more violent than elsewhere: this was the point to which he referred his greatest suffering.

Observations.—The most remarkable circumstance connected with the above case is the fact of the bladder having become ruptured, apparently as the result of the force exercised by the contraction of the abdominal muscles; for in almost all the cases on record this injury has been produced by some sort of direct violence applied to the hypogastric region. The explanation of the mechanism of this lesion, offered by Professor Harrison, will, I think, elucidate the manner in which the rupture of the bladder was produced under the peculiar circumstances of this case. When the patient's feet slipped, the abdominal muscles were thrown into strong action, in order to restore the body to the perpendicular, while the lumbar portion of the spine being violently curved backwards the promontory of the sacrum must have been tilted forward against the distended bladder. Thus the organ was placed between two forces, the contraction of the abdominal muscles in front, and the counter-resistance of the sacrum behind, in which case the same effect must be expected to ensue, as where a direct force has been applied to the hypogastric region. The bladder gives way where it is covered by peritoneum, because, as has been shown by Professor Harrison, the serous membrane being but little distensible, does not yield to a compressing force; it, therefore, cracks, and the subjacent tissues must be torn with it.

The period at which death supervened, though earlier in this than in many other instances of the same injury, forms a striking contrast to the rapidly fatal termination which occurs in cases of ruptured intestine; the mildness of the peritoneal symptoms, also, constitutes a ground of remarkable difference between these two injuries.

The method of retaining a catheter in the bladder was not resorted to in the present case, as the patient could not tolerate that plan, but even if it were possible to carry it out, it is difficult to see what good could arise from it, seeing the size and position of the rent in the bladder.

RICHMOND HOSPITAL.

Clinical Lecture on Onychia.

BY MR. HAMILTON,

SURGEON TO THE HOSPITAL.

Sometimes, in consequence of a tight shoe, the flesh at the side of the nail of the great toe is pressed against the side and upper angle or corner of the nail. Now, Dupuytren observed very truly, that in consequence of this corner of the nail being a little overlapped by a fleshy prominence, the scissors in cutting the nail are prevented from going far enough to cut this part of the nail completely, so that the angle projects in a sharp little point, which irritates the flesh pressed against it, and finally ulcerates a way into it. This is further accomplished by the pressure from above on the arch of the nail, which being flattened and straightened, the sides are forced out. The flesh, therefore, irritated and inflamed, swells, reddens, and ulcerates, and there is a thin fœtid discharge from the corner of the nail; standing or walking is painful; and the pressure of a shoe can scarcely be borne; the whole foot, when the irritation runs high, gets swollen and red, and even the lymphatics up the leg are inflamed. This is called the onychia simplex. Sometimes only one side is affected, and if so, it is generally the outside; at other times, both sides of a nail, and in some instances, both great toes suffer from this painful disease. I am inclined to think that, besides the local cause I have mentioned, the constitution has something to say to it, I have observed so many cases in delicate strumous people and in those who labour under other diseases. I operated on a gentleman who was paralytic of the whole side of the body and of speech, who had it in both great toes. There is also a young lady who is at present, and has been for the last three years, labouring under paraplegia, with cataleptic attacks, and who has been bed-ridden for that period, and, consequently, never wore a shoe, yet for a year and a half has had onychia simplex of the right great toe nail at the outside. This onychia simplex is not a disease that gets well of itself; its progress is usually from bad to worse; the swelling of the toe becomes very great, so much so, that a case is given by Dupuytren, where from the size and redness of the toe, the patient was for a long period treated for gout—a mistake, however, scarcely credible. The more the flesh swells, the greater is the pressure on the toe nail, the deeper and more extensive the ulceration from which fungoid granulations are seen to arise.

If you see this disease early, when the upper end at the side of the nail is alone engaged, you may stop it in this way:—Let the patient lay up, and poultice the toe with bread and water; this lessens the irritation and inflammation, and you will find that you will be able to insinuate, by means of a small lachrymal probe, a minute shred of lint under the angle and side of the nail, and between it and the flesh; after it is fixed in, wet it with a solution of nitrate of silver, ʒi. to the ounce; if the lint remains in, it need not be removed for forty-eight hours. You will then find the irritation and its consequences lessened, and by renewing the application two or three times, the disease will be cured; and to avoid a return, you should caution the patient when cutting his nails, to cut them straight across, to be sure there is no little projecting point at the angle, but also most particularly against rounding off the angle, which allows the flesh to be pressed over it the more readily. I cured in this way a large heavy man, foreman to Mr. Turner of the Iron Works, who had been previously treated by caustics, poultices, and ointments without any good.

When, however, the disease is more advanced, the pain and irritation excessive, it is better, after rest and poultice, and a purgative if required, to proceed with an operation, one of the most painful in surgery, though happily of short duration, by slitting up the nail and removing it. It is done in this way:—the blade of a strong short-bladed sharp-pointed scissors is passed under the nail, quite to the root, the nail is slit up in the centre, one side is seized at its middle angle with a strong forceps, and torn out by turning it over on itself. If both sides are diseased, then the other half of the nail is served in the same manner, a poultice is applied, and in a few days the part will be well. It is quite remarkable how soon a case of a year's standing is thus cured in so short a time.

Chloroform happily enables us to perform this painful operation without the consciousness of the operation.

Mrs. A. W., a rather delicate young lady, has suffered for eight months from onychia in both great toes, and on both sides of the nail in each. Great varieties of lotion, and several caustic applications have been tried in vain, and she cannot walk. I put her under the influence of chloroform, and slit up with a scissors the centre of each nail, and then with a strong forceps seized in turn the angle of each, twisted and drew them out entire and unbroken. She never felt the operation. A bread and water poultice. On the eleventh day she was just well, two little yellow spots in the centre of each nail alone remaining unhealed. The nails grew again in the course of a few weeks.

Sometimes the toe is bruised by a heavy body falling on the nail, blood is effused under the nail, inflammation, suppuration, and ulceration of more or less of the matrix ensue, with a loosening and separation of part of the nail from its bed. In this case the nail acts as a foreign body, and no relief is afforded till it is torn out.

You had an instance of this in a boy formerly in the house, on whose toe the edge of a pail fell; also in a young woman, a patient of Mr. Adams, to whom a nearly similar cause originated the injury, a bucket having crushed her toe, and with so much subsequent inflammation, that it extended to the periosteum, matter formed between it and the bone, with death of the last phalanx, which had to be removed.

George Bagnall, æt. 13. Three weeks ago a bucket fell on his right foot, and hurt the toe very much; it bled largely at the time from under the nail; he suffered much from it; inflammation took place, it got worse and worse up to the time of admission. The nail was very loosely attached, and was removed this morning by Mr. Hamilton, without much pain, though it required a sharp, strong pull. After removal, the matrix appeared raw and ulcerated at the sides, a projecting white fibrous membrane at the root of the nail, looking at first very like new nail. A bread and water poultice. A week after the surface of the matrix looked quite healed, with a new nail beginning to grow. He was dismissed. It is a good example of one form of simple onychia, the inflammation and ulceration having been caused by the crushing and tearing of the nail. In an unhealthy constitution, it would have run into the second variety, which has been called onychia maligna, from the severity of its symptoms, not from any cancerous character it possesses: it is a disease of the matrix which secretes the nail. This diseased action may be caused by an injury which crushes or tears the root of the nail in its bed, as in Bagnall's case, or by disease originally commencing at the root of the nail, with inflammation and ulceration, and finally an alteration in the nail itself, as we might expect from its secreting structure being diseased.

The toe is very much swollen, of a deep red colour, the nail is either gone, and its whole matrix converted into a large unhealthy looking ulcer, the surface greenish or black looking, with raised white callous edges, and profuse thin fetid oily, and often bloody discharge; or if there is a nail, it is quite altered, dark, thin, and even shrivelled like wet parchment, and is evidently not the cause of the state of the toe as in onychia simplex. The swelling and redness very constantly affect the foot, and I have even seen them extend some distance up the leg. Sometimes there will be a fungoid granulation springing up from the centre of the ulcerated matrix, even from the bone itself;—after the nail is gone and the disease is lessening in violence, an attempt at a new nail will be seen to be made by some white horny prominences here and there.

It is not always confined to the great toes, as I have seen it affect some of the smaller toes at the same time.

The pain is very great, and the least touch of the part gives exquisite pain; wearing a shoe is out of the question, unless the leather over the toe is cut out. There is great irritation in the system; and from that and restless nights, and want of exercise, the patient gets pale, and thin, and low spirited. The fœtor of the discharge, in spite of every care on the part of the patient, is most offensive.

It is a disease of youth rather than age: I have seen a girl ten years old affected with it.

The treatment that Dupuytren was the first to propose is very severe, indeed, though certainly very effectual; it was to remove the entire matrix of the nail: he made a deep incision with a sharp straight bistoury, in a semi-circular form, a little above the root of the matrix, and carried it round the sides; he raised with a forceps the edge of the integument next the matrix, and cut under it toward the end of the toe, keeping close to the bone, so as to remove the diseased matrix entirely. The part was to be examined closely, to see if there was any portion of the nail remaining, which was to be removed; it was then to be covered with a pledget of lint, with holes in it and smeared with cerate, and dry lint outside it, and not opened for five days.

In about a fortnight it had generally healed. You will sometimes have to perform this operation, but not often. M. Wardrop found that mercury given to salivation effected a cure; and the late Mr. Colles was in the habit of treating such cases very effectually with mercurial fumigation. You may combine these, giving three grains of blue pill three times a day, and apply mercurial fumigation daily till the sore assumes a healthy granulating surface, and the surrounding inflammation and swelling subside; the simple applications, bread and water poultice, or simple cerate dressing, may be used; sprinkling the ulcerated surface with red precipitate powder nearly answers as well as the fumigation.

The efficacy of this treatment is well illustrated by the case which has just left the house:—George Waller, ætat. 20, admitted into No. 1 Ward, April 5th, 1855; the great toe of the left foot is much swollen, of a livid red colour; the extremity bulbous, with a deep excavated ulceration, brown and sloughy on the surface, round the root and sides of the nail; the edges of the ulceration raised, sharp, indurated, and very tender; the nail is shrivelled, of a dark brown colour, easily breaking; it is firmly attached to the toe, but seems undermined by ulceration; there is profuse discharge, thin, sanious, and extremely fœtid; the redness extends up the foot and to the negihbouring toes, with some tumefaction. He suffers much pain, particularly at night. The disease is of three months' standing, beginning with ulceration at the corner of the nail—he thinks from too tight a shoe. A month after its first appearance, he was admitted into the prison hospital, where he remained for two months, the ulcer being repeatedly and freely cauterized and poulticed, but without any improvement.

He was ordered five grains of blue pill night and morning, the surface of the ulcer to be sprinkled with red precipitate powder, and the toe to be poulticed; under this treatment the part rapidly improved, and the surface of the sore became healthy; but as the nail appeared to keep up irritation, and to show no indications of separating, Mr. Hamilton put him under the influence of chloroform and removed the nail, which was very adherent at the root. On the 24th, three weeks after admission, he was dismissed cured.

If these mild means fail, you still have the operation. Before chloroform was resorted to, it was, perhaps, the most painful operation in surgery; the sensibility of the parts was so exalted—the least touch was so exquisitely felt, that no wonder the stoutest quailed at the idea of any operation on it with the knife. I saw the following remarkable instance of the shock to the nervous system, from the torture of the operation:—A little girl, about 12 years old, had onychia maligna from the fall of a stool on the toe. An incision was made beyond the matrix of the nail, and carried round the side; a similar one was made on the other side to meet it, so that the nail was completely isolated. The incision was then carried horizontally under the the nail, which was entirely removed. The girl screamed loudly during the operation, and fainted at its termination, and finally went into a fit, during which the back was arched, the arms moved about as in stretching while yawning, the eyes suffused, open, fixed, and the pupils dilated, evidently insensible to objects or to sounds—insensible in fact. After being carried to bed she went from one fit into another, the pulse very rapid and small. The fits were tranquil ones. After several hours they gradually subsided, and she got well with rather more sympathetic fever than usual.

The onychia is sometimes a syphilitic symptom, and presents itself in two forms, primary and secondary. The primary I have only seen on the fingers, generally the forefinger nail of the right hand. Here is a plate from a patient of Mr. Adams—here is another from Devergie, in which both forefinger and thumb nails are engaged. These ulcers have all the characters of chancre, a sharp raised edge, and red areola, the surface smeared with a yellow exudation, and can generally be traced to infection from contact either with chancres on the patient's own penis at the time, or his having put his cut or abraded finger from a torn hanging nail, perhaps, into some place where there were syphilitic sores.

About a year and a half ago I had a patient in No. 1 Ward, with well marked chancrous onychia of the forefinger nail, a large deep yellow ulcer round the root and inside of the nail, with a red swollen finger, and the nail loose and only hanging on by one corner. His story was that he had his finger bitten by a man who had the venereal, and was thus affected.

This drawing represents secondary syphilitic onychia of a very severe kind. You see the end of the great toe of the right foot is very much swelled, of a deep purple red colour, the nail gone, and the matrix all occupied by a deep foul ulcer, having a strong syphilitic aspect, particularly at the root of the matrix, where the edge is raised and defined, the surface covered with yellow granulations, through which some hard white granulations project. There was profuse thin fœtid discharge. The accompanying secondary symptoms were—small tubercular eruption, over the head, where some had ulcerated and were scabbed over, and on the arms, pains in his bones, and yellow ulcers in the throat, along each anterior arch of the palate. The ulcer on the great toe was sprinkled with red precipitate powder, and he was brought fully under the influence of mercury by five grains of grey powder thrice daily. The onychia rapidly assumed a healthy granulating surface, and cicatrized more quickly than I could have believed possible. In short, both for the primary and secondary onychia, mercury pushed to salivation is a certain cure.

SKIN DISEASES.

From the French of M. Maurice Chausit.

BY J. K. BARTON, A.B., M.B., T.C.D., &c.

(*Continued from page* 104.)

Passing over M. Chausit's description of urticaria, which, although clear and graphic, yet offers nothing new in the way either of arrangement or treatment, we come to Herpes, some of the forms of which M. Cazenave contends English physicians have confounded with other very different diseases, under the general name of Ringworm.

Article 4.—*Herpes.*

Definition.—Herpes is an inflammation of the skin characterized by little vesicles united in groups reposing upon a red surface, but separated by perfectly healthy skin, resulting either in a slight desquamation, or in scales, sometimes in scabs, which falling off, leave a superficial ulceration.

Herpes appears under a great variety of forms, arising either from the peculiar seat which it happens to occupy, or from the special form or nature of the eruption. This variety of form under which it appears, as it makes its diagnosis at times difficult, so necessitates its accurate study. It may be considered under the three following heads:—

1st. *True or Phlyctenoid Herpes.*

2nd. *Herpes appearing in peculiar localities.*

3rd. *Herpes, with some special and distinctive external characters.*

Phlyctenoid Herpes may appear upon any part of the body, but generally chooses the chest, face, neck, or upper extremities, and when in any of the extremities, prefers the neighbourhood of the articulations. It is characterized by an eruption of vesicles, generally small, but frequently the size of a pea, distributed in distinct groups, the size of which varies from that of a five shilling piece to the palm of the hand, reposing upon a red irregular surface, but always distinctly limited; the groups are separated by the skin in its natural and healthy state. In general phlyctenoid herpes pursues a rapid course, terminating in seven or eight days; sometimes its duration is prolonged by successive crops of vesicles, and in this way it sometimes continues for a length of time. Very slight general disturbance accompanies it; locally the disease is announced by a sensation of heat and burning. If we examine the part thus complained of before the herpes appears, we will see a number of red points crowded together in a very small patch; the day after this patch will be enlarged, and upon the red surface we will see a number of little globular, transparent vesicles. The eruption is complete upon the fourth or fifth day, the vesicles become flattened, mostly from absorption of their contents, and the whole terminates about the seventh day by a slight desquamation; if the vesicles burst, as is not unfrequently the case, the serosity which escapes forms light scabs, which soon fall, leaving an obscure red mark: such is the course of phlyctenoid herpes in its acute form. When it exists in a chronic state, it is continued by successive eruptions, which either appear on the same site or invade the healthy skin. M. Cazenave has observed, that when the seat of the eruption is round some of the articulations, it has a tendency to become chronic.

Causes.—Phlyctenoid herpes may be developed under the influence of either external or internal causes; it arises most frequently from the latter. M. Cazenave has found it often produced by moral causes, also by excess of nourishment, and prolonged toil. In all cases it is necessary to consider as the predisposing cause, a delicate constitution, or a fine and white skin. Thus it affects, by preference, women, and the young of both sexes.

Inflammation shows itself in herpes in a double manner, first, by congestion, and secondly, by serous secretion, which last exists in less extent, and is less marked than in eczema, of which it may be considered the special characteristic.

Treatment.—The general treatment consists in the employment of acidulated drinks, when the bowels have been evacuated; seldom any further measures are required. Topically, mucilaginous lotions, and the tepid bath, are useful.

II. *Varieties of Seat.*

1st. *Herpes Labialis.*—This variety, from its seat, which is around the mouth, generally at the juncture of the mucous membrane and skin, gives to the countenance a peculiar and distinct expression. It is very often preceded and announced by a general *malaise*, which exists for twenty-four or forty-eight hours before the eruption appears, whilst the lip about to be affected is the seat of a feeling of tension and heat. The pain and heat diminish as the eruption becomes developed, but the swelling remains around the bases of the vesicles, which are clear, as if distended with air; soon, however, the serous fluid which they contain becomes turbid, then lactescent, and finally presents a sero-purulent appearance. This transformation is generally completed about the fourth day, then each vesicle covers itself with a yellow crust, which falls off gradually about the seventh or eighth day.

Causes.—Herpes labialis seems to be developed most frequently under the influence of direct causes, either a cold wind, or the contact of certain irritating kinds of food or drink; it sometimes accompanies coryza, or stomatitis, and by no means unfrequently appears consecutively with severe inflammation in the chest, particularly pneumonia. M. Cazenave has seen it appear with an attack of intermittent fever.

2nd. *Herpes Preputialis.*—This variety possesses not only a peculiar physiognomy, but a real importance in a diagnostic point of view. It is characterized by small groups of vesicles, about the size of a shilling, situated either on the outer or inner surface of the prepuce, or it may be upon both at the same time; it exists either in an acute or chronic form.

When acute, it appears without any precursory symptoms, in the form of small red patches, upon which, about the second day, vesicles are developed, the continuation and course of which will vary, as they appear upon the internal or external surface of the prepuce; in the latter case there is a slight feeling of heat and itching which soon passes off; upon the fourth or fifth day the vesicles become flat, and the disease terminates in seven or eight days, with a slight desquamation. When the disease appears upon the internal surface of the prepuce, the inflammation is more acute, the individual course of the vesicles is more rapid—they are very transparent, and as they rest upon a visibly red surface, they appear themselves of a bright red colour. Towards the sixth day the vesicles in general burst, and are replaced by superficial erosions, which preserve the rounded form of the vesicle, a character which may be a cause of error; these little excoriations last but a short time—they disappear in two or three days, without leaving any trace whatever.

Chronic Herpes Preputialis, first described by Biett, and afterwards by Cazenave, is a malady of considerable gravity. The disease is prolonged by successive eruptions, each of which individually has an acute course; they return after shorter and shorter intervals, and soon produce very serious effects; the inflammation extending to the internal surface of the prepuce causes it to become thick and rough, and any attempt to draw it back produces laceration of the lining membrane, and soon the manœuvre becomes impossible; the edge of the prepuce is converted into a kind of ring thick and inflexible, which prevents the glans being uncovered; the orifice becomes narrower by degrees as the inflammation continues, until it prevents the free passage of the urine; the glans and prepuce are bathed in the secretion, whenever the patient makes water, and this again tends to keep up the inflammation. Any attempt forcibly to draw back the prepuce causes painful laceration, and severe paraphimosis has been the result when accomplished. The unpleasant consequences of the incomplete expulsion of the urine, the itching arising from the retained sebaceous secretion, and the constant irritation of the part, make chronic herpes preputialis a most annoying malady to the patient, and one which frequently produces great depression and melancholy.

Causes.—Herpes Preputialis seems most frequently to be produced from some local external cause. M. Cazenave has seen it caused by the rubbing of the linen, from the contact of some chronic vaginal discharges, or from the sebaceous secretion accumulated between the prepuce and the glans, in persons careless of cleanliness.

Topical irritants, unwisely prescribed in acute herpes, have converted it into the chronic form.

From its seat, herpes preputialis is liable to be mistaken for a much more serious class of diseases, and hence may lead to the employment of remedies, the least objection to which will be that they are useless. The theory which supposes a chancre to commence as a vesicle makes the mistake more specious and easier.

In reality, however, the vesicular character may be looked upon as quite peculiar to herpes, which, as long as there are vesicles, will be readily distinguished from the ulcerative inflammation produced by the venereal poison. Nor will these superficial erosions, which remain after the vesicles have disappeared, be mistaken if the distinctive character of the venereal ulcer be remembered.

Treatment.—In the acute form, emollient topical applications and mucilaginous injections between the prepuce and the glans, when the eruption is situated there, will be useful. When the disease has become chronic, it frequently resists every measure to put a stop to it, and will require great perseverance both on the part of the physician and his patient. Emollient injections may be alternated with alkaline, combined with alkaline or sulphur baths. M. Cazenave has employed, with success, an ointment of the white oxyde of zinc, in the proportion of ʒss. of the oxyde to ℥i. of lard. Internal treatment must also be employed; and we would advise in this respect repeated laxatives, Plummer's pill, and the natural sulphurous waters. In order to prevent the narrowing and closing of the preputial orifice M. Cazenave is accustomed to introduce between the prepuce and the glans a piece of prepared sponge, and has thus rendered unnecessary the operation for phimosis, which should only be resorted to when evidently indispensable.

3. *Herpes Tonsurant.*—The name of ringworm has been applied for a long time by English physicians to a form of porrigo, viz., porrigo scutulata. Under this name, however, several dissimilar diseases seem to have been generally confounded, and amongst others this form of herpes. Biett first recognized a form of contagious herpes occupying the scalp, but M. Cazenave first clearly described and rescued this disease from confusion with others. In August, 1840, he was called to a school in Paris to give his advice upon a disease of the scalp, which had spread through a number of the children in the establishment. After a careful study of this disease in its various stages, he came to the conclusion that it was a form of herpes, already recognized by Biett, as a contagious variety, and named it *herpes tonsurant.*

Definition and Symptoms.—*Herpes tonsurant* is a disease peculiar to the scalp, specially characterized by its contagious nature; it consists of rounded patches of irregular size, with a tendency constantly to extend their margin, dry, greyish, and scaly over the whole surface, and presenting, as a peculiar and distinctive characteristic, a baldness in the shape of a *tonsure*, caused, not by the falling out of the hair, but by its being broken short off close to the scalp. The appearance of the disease is not preceded by any general disturbance, or any of the usual local phenomena, viz., heat, itching, &c. A little round spot is first seen, which constantly enlarges; this is at first covered by a number of minute vesicles, which, however, are so short-lived, that they usually escape detection, and the desquamation in which they result is alone observed. The hair will be, upon close observation, found broken off close to the scalp over the spot; further than this, however, and a slight furfuraceous appearance, the patch presents no appreciable disease; it has the same appearance over its whole extent, but exhibits in no part any moisture or secretion whatever. Nevertheless it continues constantly to increase, preserving its rounded form.

Frequently only one patch exists, but they are numerous sometimes, and M. Cazenave relates a case of a child who had thirty-two distinct patches at one time over the scalp. They present a striking contrast to the well-covered parts of the head which surround them, both from their clearly marked edge, always circular, and their whitish scaly appearance. As the patches, if unchecked, constantly enlarge, they after some time become all joined and confounded together, forming one large tonsure, limited by the half and quarter circles which formed the boundaries of the primitive disc.

At first sight, one feels inclined to deny the herpetic nature of this disease altogether, but the two following facts seem to decide the question:—M. Cazenave has frequently observed in the St. Louis Hospital, in cases where the disease was old and well marked, patches of *herpes circini* upon the neck, cheeks, or round somewhere near the edge of the scalp. And in the horse a patch of herpes has been frequently seen extending across the line of junction between the scalp and the skin, to present, in the first, the characters of *herpes tonsurant,* and in the second, those of herpes circini.

Herpes tonsurant has always a chronic course, it lasts for months, sometimes for years. When the disease is getting well, the patches loose gradually their furfuraceous appearance, the skin becomes smooth and shining, the hair begins to grow, and quickly furnishes again the affected parts.

This herpes only attacks the young; it appears to have no tendency to relapse; it prefers the parietal and posterior parts of the head.

Causes.—What may be the original cause of *herpes tonsurant* we know not, but that it is essentially contagious is amply proved by repeated observation, so that no doubt remains upon this important point. What is then the contagious principle of this herpes? This as yet remains an undecided point. Why this form of herpes, on account of its special seat, should be contagious, while other forms occupying the skin are not so, seems very curious.

The fact of its contagious nature, however, renders an accurate diagnosis extremely important.

Treatment.—No general disturbance accompanies this form of herpes, indicating the employment of internal remedies. The treatment consists chiefly in the use of mild topical applications. M. Cazenave has found that irritating ointments, caustics, or blisters, cause such local irritation and inflammation as to bring out an eruption of pustules, in fact to produce an impetigo. A great number of ointments have been used, composed of the carbonate of potash or borate of soda, or calomel, in the proportion of ʒss. or ʒi. to ℥i. of lard. M. Cazenave has, however, employed the two following with most advantage, viz.:—1. Citrine ointment ℥i., pitch ℥ss.; or 2. Tannin, 15 to 30 gr. to ℥i. of lard. The affected parts of the scalp having been rubbed with one of these ointments at night, is to be washed with an alcaline lotion in the morning; a steam douche directed against the part has been found very useful, but it ought to be taken at 32° R., and for ten minutes or more.

Varieties of Form.

1. *Herpes Zoster, or Zona.*—*Definition.*—The zona is characterized by irregular red patches, covered with vesicles of variable size, agglomerated together. These patches are the seat of an acute pain; they are generally separated by portions of healthy skin, and present the pathognomonic character of being disposed in the form of a half belt round the body (*demi-ceinture*).

Symptoms.—Sometimes the disease appears without any marked precursory symptoms; often, on the contrary, it is announced by a feeling of malaise and darting pains where the eruption is about to appear; then some red patches make their appearances, of variable extent, generally at the extreme points of the semicircle. Towards the second day, if we observe the patches with attention, we will see them covered with vesicular points, at first so transparent that they appear of a rose-colour from the surface which they cover; soon, however, the serosity which they contain becomes turbid. About the fourth day they attain their greatest size, which varies from that of a millet seed to a small pea; they are never confluent, however closely placed together they are always distinct. From the fifth day of their individual duration, each group enters the period of its decline, the liquid contained in the vesicles becomes more and more turbid, they get pale, finally become flattened and disappear, and are replaced by little brown scales, but slightly adherent, which, falling, leave brownish marks which remain for some time. The disease altogether is generally terminated in ten or twelve days. If, however, the vesicles, from the rubbing of the clothes, are ruptured, they frequently leave small superficial excoriations, which are very painful, and prolong the sufferings of the patient for some time. In cachectic subjects and old persons, the vesicles are often large and soft, burst very early, and give exit to a sanious discharge, followed by whitish unhealthy ulcerations, which cause great pain, and heal very slowly.

The pain which accompanies this form of herpes is always a marked symptom; it precedes the eruption somewhat, in general; and consists in darting, lancinating pains, through the chest, and a sensation of heat and burning at the seat of the eruption.

Herpes Zoster is always an acute disease.

Causes.—Observation has established that herpes zoster is more frequent in young subjects and in individuals of a fine skin and sanguine temperament; it appears, too, to be under the influence of atmospheric changes. M. Cazenave has remarked it much more common in summer than in the other seasons. There is no doubt that it is sometimes caused by very acute moral emotions, and in such cases is accompanied by severe neuralgic pains. Direct causes seem in general to have no influence in producing it; but a case has lately been observed in which a single friction of mercurial ointment was followed by the eruption.

Treatment.—In the greater number of cases, if not in all, the treatment of herpes zoster is as simple as it is easy. Rest, diluent drinks, tepid baths towards the close of the attack, suffice to complete the cure; it is rare to be compelled to use any more active means. The acute nature of the eruption, and the pain which accompanies it, seem to indicate the employment of emollient topical applications; poultices, however, have the effect of softening and macerating the vesicles, so that they are ruptured with facility, and are followed by little ulcerations, which retard the cure, and are a source of suffering to the patient.

M. Cazenave has employed for some time an application which has the double advantage of shortening the duration of the vesicles, and relieving the local pain. He powders the affected surface with dry starch, and applies over this blotting paper soaked in almond oil, the result of which inert covering is, that the vesicles pass through all their stages without danger of rupture, and the duration of the disease is abridged.

2. *Herpes Circini.*—This variety of herpes, on account of its remarkable form, constitutes a well-marked division. It is characterized by patches of variable size, but always rounded into regular circles, of which the centre is unaffected and healthy, the circumference of which forms a ring, covered with minute vesicles, which pass quickly away, and are replaced by scabs, sometimes so thin and fine, that they give rise to a kind of mealy appearance of the part.

Herpes circini is not announced by any general disturbance; it comes out spontaneously by little red spots, which generally are not larger than the point of the finger, and which, although of a regular and defined form, yet do not present at first the perfectly circular form and healthy centre which are characteristic of it afterwards.

The vesicles which cover the ring are not always easily seen, for the serum which they contain generally remains quite clear, and their whole duration is short. The rings increase in size by an excentric movement; the healthy skin in the centre increasing in size while the ring enlarges: if they are numerous they frequently join and become confounded together. Eight or ten days is the general duration of the malady, when two or three patches are developed; but when numerous patches follow one another in succession, the disease may be prolonged for three or four weeks. After all desquamation has ceased a reddish ring will remain for some time, particularly in individuals of a fine and susceptible skin.

Herpes circini selects as its usual seat the face, neck, and chest. It seems to be a disease peculiar to children, young girls, and individuals of a very fine white skin.

Treatment.—Herpes circini is always a mild affection. We will hasten its cure, however, by the employment of slightly acid lotions, such as bran water acidulated with lemon juice, or alkaline lotions, rendered slightly astringent by the addition of a little alum or sulphate of zinc. If the eruption be very extensive it will be necessary to administer laxatives, but severer measures than these are never requisite.

Scaly Herpes, which is described as the third, under the head of *Varieties in Form*, seems to be merely a variety of the last described form, viz., herpes circini, and differs from it in so few particulars as scarcely to admit of a separate description.

The fourth and last variety is *Herpes Iris*, so named from the curious feature which it presents, viz., exhibiting a number of different colours: the patches which constitute the disease present from the centre to the circumference generally four different shades of colour. It appears in the form of little red spots, which separate into little zones of different shades of colour. On the second day the centre of the patch will be found covered with a group of little globular transparent vesicles, when these fade on the fourth or fifth day, the centre presents a yellowish colour, at the same time the erythematous zones, which surround the central patch of vesicles, extend themselves and become less distinctly separate, but are marked by different tints of colour, probably the result of different degrees of erythematous congestion which surrounds the herpes. When they are very distinct they form four distinct rings, arranged like the colours in a cockade in successive circles; first a reddish brown, then a yellow white, then a deep red, and then a diffused red losing itself in the natural colour of the surrounding skin.

Herpes iris exists sometimes concurrently with other varieties of herpes. It is developed under the same conditions as herpes circini, and like it prefers as its seat the face, or part of the chest; sometimes we encounter it on such salient points as the malleoli or elbow.

It is a mild affection demanding no particular treatment.

SELECTIONS FROM BRITISH AND FOREIGN JOURNALS, &c.

Case of Malformation of the Sternum.—Alexander Graux, 25 years of age, presented himself before M. Aran, exhibiting a malformation of the sternum, consisting in an almost entire division of that bone along its mesial line.

In the whole of the region naturally occupied by the sternum there existed a depression or gutter-like cleft, its walls formed by the integument only. This depression was about three and a-half inches in length, measuring it vertically from a line drawn from one clavicle to the other, and assumed a triangular shape, the base above in the space between the two clavicles, and the apex below. At its base it measured about two-thirds of an inch, and at its apex about an eighth. The dimensions of this furrow could be considerably increased at the pleasure of the patient by putting his pectoral muscles into strong action, the integument covering it being then stretched so as to occupy the same level as the rest of the wall of the thorax, the depression being entirely effaced.

When in a state of repose an osseous rim, evidently formed by the two halves of the sternum, was distinctly seen on either side of the cleft, and to this the ribs were connected in the usual manner. This malformation entailed some considerable modification in the relations of the osseous and muscular structures of the neck and chest. The clavicles, natural in their curve and structure, terminate in a large extremity above either half of the sternum, without any trace of a sterno-clavicular articulation. The sterno-cleido mastoid muscles arise from the clavicle only; properly speaking they are cleido-mastoid, the right sterno-hyoid and thyroid are absent, but on the left side they can be seen, during a deep inspiration, resembling two prominent cords. The respiratory functions are no less considerably modified by this malformation. An ordinary inspiration is at once diaphragmatic and superior costal, with this peculiarity, that the diaphragm acts first, the upper ribs rising after the commencement of the recoil of the abdominal walls. During a deep inspiration the chest is raised and enlarged by the trapezius and sterno-mastoid on either side, while there is no proportionate increase in the action of the diaphragm and upper ribs. There is nothing remarkable in an ordinary inspiration, but during a forced one the chest and the abdomen retract, the veins of the neck become conspicuous, some of the intercostal spaces become convex on the outer surface, and then the fissure commences to rise from its middle upwards until the integument becomes level with, or even projects beyond the level of the neighbouring structures.

Owing to this malformation the mode of performing some of the functions of the heart can be studied through the thin covering of integument. About the middle of the fissure an oblong tumour alternately dilates and contracts from sixty to sixty-four times in the minute. When most dilated the tumour is about two inches in its greatest or vertical diameter, and it diminishes from one-half to two-thirds when contracting from above downwards; and from the right to the left side, the dilating and the contracting alternate, and the former occupies rather more time than the latter. This pulsating tumour is relatively less resonant on percussion than the neighbouring parts, and this dulness is continuous with that of the ventricles, or of the heart properly so called, measuring three inches from side to side, reckoning from the mesial line, and three and a-half from above downwards. At the level of the tumour the two sounds of the heart are very loud and clear, especially the second. At the boundary of the ventricular dulness, which extends beyond the level of the impulse, the two are equally loud, clear, and nearly of the same duration; but ascending obliquely towards the base the second sound becomes stronger and clearer, and near the sternum the first acquires a blowing character. The second sound derived from the pulmonary artery is more distinct and superficial than that of the aorta. When the hand is placed upon the spot at which the impulse is most distinctly felt, viz., in the fourth intercostal space close to the nipple, when the patient is lying down, or a little below the fifth rib if he is standing, this impulse is found exactly to coincide with the commencement of the contraction of the tumour. If the fingers are placed on the radial or the carotid while the eye attentively watches the movements of the subcutaneous tumour, an appreciable interval is noticed between its contraction and the dilating of the artery, the latter being always consecutive.

Such are the principal peculiarities presented by this malformation. The young man enjoys excellent health, though of a feeble appearance. For the present we record the phenomenon without seeking to deduce from it any argument in reference to the many different theories respecting the movements of the heart, and we abstain from bringing forward the diverse explanations which have been already offered.

A commission composed of MM. Aran, Beau, Béheir, Bouvier, Hérard, and Monneret has been requested to report upon the subject to the Medical Society of the Hospitals.—*Gazette des Hôpitaux.*

Mr. Prescott Hewitt's Lectures.—Mr. Prescott Hewitt has delivered a very interesting and practical course of lectures at the Royal College of Surgeons. The first subject chosen being the Anatomy of the Head or Skull; and the second subject, Injuries of the Scalp or Skull. In the first lecture, a variety of magnified diagrams of sections of the scalp, including cutis, fibro-cellular bands, various aponeuroses, fat deeply imbedded in cellulo-adipose tissue, occipito-frontalis attachments, numerous openings for vessels and nerves, &c., were all explained. The different bearings of these parts on the surgical treatment of scalp wounds were also well shown in the subsequent lectures. The arteries of the pericranium or scalp were described, in what Professor Hewitt styled three strata, to borrow a geological phrase—first, those above the occipito-frontalis, rich and large; second, those in the laminated cellular tissue *under* the occipito-frontalis; third, those of the pericranium itself, very small. Save the pulps of the fingers, no part of the body is so vascular—explaining why large flaps of integument of the skull knocked off in injuries healed so well by "first intention:" sometimes what would be lacerated wounds of scalp from a blunt instrument, seem as if clean incised wounds—a point necessary to be remembered at coroners' inquests. Again: serum or lymph, the lecturer observed, by the binding down of these layers of tissue constituting the scalp, are readily diffused under this musculo-aponeurotic layer, indicating the necessity of early but small incisions in such scalp injuries; such effusions may go to the face, or even to the mouth. He had removed a tumour himself which even went through the perpendicular plate of the palate bone into the temporal fossa! If on one side we have such dangers to avoid, on the other we have the advantages of the flaps of such wounds carrying their own blood, as shown in the diagrams, freely inosculating from one side to the opposite. Hence so little sloughing in scalp wounds. The pericranium, it must be remembered, receives its vessels through the "holes"—pin holes, as one might call them—previously shown in the diagrams. Again, he may have severe hæmorrhage to deal with, as when a drunken man falls out of an omnibus on his head; but pressure here, as recommended by French surgeons in extreme cases, will be very seldom necessary. If a small spouting artery is found, it should be tied; but otherwise, "first intention" encouraged. In subsequent lectures, the anatomy of the scalp was resumed, but more particularly in relation to the osseous structures of the head underneath, and more specifically as to the outer and inner tables of the skull. The relations of the various bones with their sutures were first pointed out: the inflexions of dura mater forming internal periosteum, the superior longitudinal and other sinuses, meningeal vessels, &c.—all very elementary as studies, but necessary, to simplify and render the subject more perfect. The lecturer dwelt very particularly on an abnormal distribution of the middle meningeal artery, which he had observed in two skulls in the Hunterian museum of the College; this artery, in place of ascending in the familiar dissecting-room fashion through the foramen-spinosum of the sphenoid as one branch, formed, in fact, two branches. These arteries, it would be remembered, might be lacerated without fracture, or be met with in "out-of-the-way" places by the trephine. All this was a sort of philosophy of "small things" not to be forgotten. Professor Hewitt next explained the different relations of the diploe of the cranial bones to injuries of the head. The internal plate of the cranial bones in the human subject, as Professor Quekett has shown microscopically, was not so vascular as the external. There were also comparatively no "*Haversian canals,*" in a vertical section, of one of these bones, towards the inner side of the skull, or in what is known as the inner or vitreous table; while, on the other hand, the external and middle layers were highly vascular, and marked also by those peculiar canals. If this bone is, therefore, thin and glass-like, so to speak, it will not bleed; it will crack and splinter; but if thick and vascular (though not agreeing to a view once held by Abernethy), it will bleed, and be driven in or bulged. The lecturer next exhibited several human skulls, without diploe or frontal sinuses; but these were by far the exception to the rule. He spoke also of the mode and period of age of development of the frontal sinuses. Mr. Hilton, he said—a good authority on all that relates to the skull—said fourteen or fifteen years of age was the time when the frontal sinuses first appeared. The bearing of this point on injuries of the skull in young subjects, and the necessity of avoiding the operation of trephining, were next entered into at some length. Emphysema, or air in the cellular tissue of the face, and pain in the forehead, as in ordinary catarrh, very clearly indicated something wrong in the frontal sinuses; the anterior portion of the brain, also, was not so essential to mere animal life, as the base or posterior parts; so that practically all injuries of the bones of the skull anteriorly, and over the frontal sinuses, were, as in the lower animals—the elephant, for instance—not so dangerous.

On the Influence of the Valve-Diseases on the Walls and Cavities of the Heart. By Dr. Sibson.—Senac proved that obstruction to the flow of blood from either ventricle induced dilatation of that ventricle. Obstruction to the circulation through the lungs, as from bronchitis, emphysema, or condensation of either lung, induces dilatation, with hypertrophy of the right ventricle, and dilatation of the right auricle. Obstruction to the systemic circulation produces the same effects on the left ventricle and auricle. Thus, aneurism, atheroma, dilatation and narrowing of the aorta and its branches, cause hypertrophy, with dilatation of the left ventricle. The same effect is induced by resistance to the circulation through the sytemic capillaries, as in a moiety of the cases of Bright's disease. The retrograde influence of the obstruction to the circulation through the capillaries induces active dilatation of the *left* ventricle in cases of morbus Brightii, and of the *right* ventricle in cases of emphysema. Obstruction in the systemic capillaries is probably the cause of hypertrophy and dilatation of the left ventricle in a large proportion of those cases in which there is no other assignable cause. In some cases of pericardial adhesion without valve disease, there is dilatation and hypertrophy of both ventricles; in other cases, when the adhesions are long and loose, the heart is of a normal size; while, in other cases, when the adhesions are tight and tendinous or bony, so as to constrict the ventricles, the heart is lessened in size. Narrowing of the aortic aperture, with or without regurgitation, causes hypertrophy, with dilatation of the left ventricle. The same effect is induced by regurgitation through the inadequate aortic valves, when the aperture is not narrowed. Dr. Peacock has observed, that in case of aortic obstruction, the cavity of the left ventricle is peculiarly elongated, and its walls are thicker near the base than elsewhere; and that in cases of aortic regurgitation, while the left ventricle is elongated the thickening of its walls is more equally distributed, and the apex, instead of being pointed, is obtuse. The obstructive and regurgitant diseases of the pulmonary artery excite active dilatation of the right ventricle. Mitral regurgitation causes, first, dilatation of the left auricle, and obstruction to the circulation through the lungs, and as a secondary effect on this obstruction to the pulmonary circulation, hypertrophy, with dilatation of the right ventricle. In the chain of consecutive effects, the right auricle becomes dilated, owing to the difficulty with which the blood leaves and enters the right cavities; the liver, and the head and neck become congested, and after a time, the circulation through the systemic capillaries is obstructed, and, as a consequence, the left ventricle is at length dilated and hypertrophied. The right ventricle is actively dilated in nearly every case of mitral regurgitation; the left ventricle is so in about one-half of the cases. Aortic narrowing and regurgitation is followed by a like series of morbid effects, each of which becomes in turn an obstructive cause. Thus the hypertrophy and dilatation of the left ventricle is followed consecutively by dilatation of the left auricle, obstruction to the pulmonary circulation, active dilatation of the left ventricle, dilatation of the right auricle, and congestion of the liver, and head, and neck. In nearly all cases of aortic obstruction and regurgitation, the left ventricle is actively dilated, and the right ventricle is so in about one-half of the cases. When there is both aortic and mitral regurgitation, the effects of each of these valve diseases on the walls and cavities of the heart is simultaneously induced. Since, however, the influence, *à tergo,* of the aortic valve-disease on the left ventricle, is more immediate than that of the mitral valve-disease on the right ventricle, the left ventricle is, in such cases, somewhat more frequently hypertrophied and dilated than the right ventricle. The diagnosis of aortic and mitral valve-disease is decidedly facilitated by observing whether the right or the left ventricle be enlarged. If the left ventricle be enlarged, as in aortic valve-disease, the apex beat is stronger, lower, and more to the left than usual. If the right ventricle be enlarged, as in mitral valve-disease, the impulse is strong and diffused over the lower half of the sternum, and the adjoining left inter-cartilaginous spaces, while the apex-beat is either normal, or less marked than in health. When the right ventricle is enlarged in cases of emphysema, the enlarged lung covers the enlarged heart so as to prevent the impulse from being felt over the sternum or intercostal spaces. The heart's beat is then, in fact, transferred to the space below the sternum, and to the left of the xiphoid cartilage, owing to the heart being lowered, as well as the lungs, by the unusual descent of the diaphragm. In cases of combined aortic and mitral valve-disease, the impulse at the apex is lowered, and more to the left, while that over and adjoining the lower end of the sternum is unusually strong and heaving.

Treatment of Aneurism by Electricity. By —— Samoje, M.D.—Dr. Samoje, of the Berlin University, made some remarks on the coagulation of blood by electrical means, for the purpose of curing aneurisms and varices. After having noticed the labours of Asinelli, Petréquin, and Schuh, on galvano-puncture of arteries and veins, he referred to a case of a young girl operated on by Drs. Baumgartner and Wertheimer, in M. Malgaigne's presence, which gave most valuable evidence of the *modus operandi* of this treatment. This young girl had suffered for a long time from a varicose degeneration of all the large and small veins of one arm, extending to the acromion. The circumference of the arm was increased to double its size. The disease was traced to an extreme thinness of the membranes of the veins. Drs. Baumgartner and Wertheimer introduced, at intervals of two or three days each time, ten needles into the veins, the patient holding the negative conductors with the hand, while the positive pole was connected with the heads of all the needles. After removing the needles, a few minutes having elapsed, very resistent filaments could be felt as signs of an accomplished coagulation. The operation caused but little pain. Four weeks ago the varicose veins appeared obliterated, and the circumference of the arm was remarkably reduced. Drs. Baumgartner and Wertheimer observed, in their frequent experiments on animals, the following facts regarding the mode of applying the galvanic current, for the purpose of producing coagulation. 1. If the needle connected with the negative pole be introduced alone into the vessel, and the positive conductor be laid upon the neighbouring parts of the body, no coagulation will take place. 2. If both poles be introduced into the vessel, coagulation occurs only slowly, and is seldom accomplished. 3. If the positive pole alone be introduced, and the negative be laid upon the neighbouring parts, coagulation takes place always soon and perfectly.

Dr. Samoje mentioned also two other methods of employing electricity for coagulating blood. He tried successfully to substitute for the primitive current the intermittent current of a coil machine, in which the wires of the primitive and secondary are connected together. Considering the greater intensity by which the latter is enabled to penetrate the membranes of the vessel, he tried it on a large painful hæmorrhoidical varix, which had lasted during many years. The tumour was taken between one conductor armed with some moistened sponge, and the other pointed with a flat button, and held in this situation during a quarter of an hour. Every day, this being repeated, the varix decreased gradually, till on the tenth day it was collapsed to a wrinkled sac with resistent contents, causing no more pain. It had not returned six weeks ago, when the patient was inspected the last time. The third mode of coagulating blood in the vessels by electrical means tried by Dr. Samoje, was the use of a platina wire heated by a galvanic current. He alluded to a paper of Sir Everard Home, read to the Royal Society in 1826. The author had proved there that a steel needle, heated red-hot, produced a coagulum capable of obliterating a large artery. Equally fit, but more applicable and more advantageous, appeared the use of the constant heat of the platina wire under the influence of a galvanic current.

The Belfast Clinical and Pathological Society.—At the annual meeting of this body, held on Saturday, the 5th instant, in the Library-room of the Medical Society, in the General Hospital, Frederick-street, Dr. J. C. Ferguson, the outgoing President, in the chair, the following officers were elected by general ballot for the ensuing year, viz.:—President, Dr. Malcolm; Town Vice-Presidents, Dr. M'Gee, Surgeon Browne, and Dr. M'Cormac; Country Vice-Presidents, Dr. Young (Holywood), and Dr. MacLoughlin (Lurgan); Members of Council, Drs. Murney, Pirrie, Stewart (Robert), Dill, Lynch, and Patterson; Treasurer, Dr. Halliday (re-election); joint Secretaries, Surgeon Johnstone (re-election) and Dr. Ross. A vote of thanks was passed to Dr. J. C. Ferguson on his retirement from the presidentship. Thanks also were unanimously passed to all the other office bearers, for the very efficient manner in which they had discharged their several duties, especially the outgoing secretary, Dr. Malcolm, who is now advanced to the highest honour the Society can confer upon him. Two honorary members were also balloted for, and unanimously admitted—viz., Dr. Stokes, of Dublin, and Dr. Smith, Professor of Surgery in the University of Dublin. The report of the proceedings of the past year was read by Dr. H. Johnstone, from which it appeared that the Society now counted 105 members, 45 of whom were resident practitioners of Belfast, and 60 non-resident, and not confined to the adjoining counties or towns merely, nor even to the most distant parts of the province of Ulster, but in the metropolis, and the south and west part of Ireland were members residing, and in England also, so high a name and position has this Society arrived at. A reference was made in the report to the decease of the late Dr. J. W. Bryson, who was a member at the time of his premature and much-regretted death, and who always enjoyed, it was stated, the largest share of the confidence and respect both of the profession and the public. The report mentioned that the utmost good feeling and harmony prevailed at the weekly meetings of the Society, which were always numerously attended, and at which many cases of the deepest professional interest were brought forward, and discussed in a manner that could not but be profitable to all present. An important feature in the conduct of the Society is, that advanced medical students are permitted the privilege of attending its discussions—a privilege which is shown to be highly prized by them, as it should be, so many as forty-three having availed themselves of it. A *conversazione* was afterwards held at the Corn Exchange, and was attended by upwards of one hundred gentlemen. Dr. Ferguson delivered an eloquent address on the close of the session.

DUBLIN: PUBLISHED BY W. B. KELLY,
8, GRAFTON-STREET.
LONDON: S. HIGHLEY, 32, FLEET-STREET.
EDINBURGH: MACLACHLAN & STEWART.
June 1, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.

SENT FREE BY POST.

Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 10.—Vol. II. JUNE 15, 1855. Price 5d.

JERVIS-STREET HOSPITAL.

A Case of Fracture of the Spine in the Cervical Region; with Observations.

BY JAMES STANNUS HUGHES, M.D., F.R.C.S.I.,

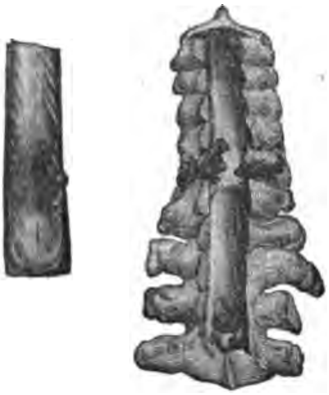
SURGEON TO THE HOSPITAL, EXAMINER IN SURGERY IN THE QUEEN'S UNIVERSITY IN IRELAND.

The subject of the accident, J. D., was a strong, healthy man, of 35 years of age, who, whilst working in the hold of the "Albatross" steamship, then lying in the River Liffey, was struck by a large sack of oatmeal, which, having slipped from the slings, struck him on the back of the neck near the shoulders; the patient was felled by the blow, and soon after the accident was carried to Jervis-street Hospital, labouring under all the symptoms of fracture of the spine in the cervical region, below the origin of the phrenic nerve, viz., there was complete loss of motion and sensation of the lower extremities, with partial loss of motion and sensation of the upper limbs; the respiration was extremely laboured, being principally carried on by the diaphragm, the abdominal and intercostal muscles being paralysed; the pulse was unusually slow, being only 36 in the minute; the extremities were cold; there was a total loss of power over the bladder; the penis was in a semi-erect state; the abdomen became tympanitic immediately after the accident. On examination after admission a fracture of the spinous process of the fifth cervical vertebra was detected. The patient lived for four days, and up to within a few minutes of his death he could not be persuaded of his danger, being, as he expressed himself, "so free from pain and suffering of any description."

The apparent immediate cause of death was *apnœa*, from effusion into the bronchial tubes. It is to be added, that the urine, which was drawn off two or three times daily by means of a catheter, remained acid to the last moment of life.

Autopsy.—On removing the superincumbent parts from the posterior aspect of the cervical vertebræ, a fracture of the spinous process of the fifth cervical vertebra, involving the left lateral lamina, was revealed; in addition to which a fracture was ascertained running through the bodies of the fifth and sixth cervical vertebræ. A considerable effusion of blood had taken place both internal and external to the theca vertebralis at the seat of injury; the spinal chord was in a softened and highly vascular condition, not only where the displaced body of the sixth cervical vertebra and the effused blood had exercised a considerable amount of pressure, but likewise for some distance both above and below that point.

The accompanying woodcut, executed by Oldham, after a drawing by Connolly, which was reduced by my friend, Mr. Frederick Sanders, to its present dimensions, through means of the photographic process, beautifully and faithfully exhibits the morbid appearances just referred to.



Observations.—The foregoing case exemplifies the train of symptoms which usually follow on fractures of the spine in the cervical region, when occurring below the origin of the phrenic nerve, whilst the *post mortem* appearances, the chief points of interest, not only exhibit the ordinary results of these formidable accidents, but account for the failure of the operations, which have been proposed, and practised for their relief.

There are two questions which naturally suggest themselves in connexion with the treatment of fractures of the spine, with displacement, namely—1st, Should a reduction of the fracture be attempted? 2nd, Should the surgeon, in a case of fracture of the vertebræ, followed by displacement and paralysis, proceed to cut through the superincumbent parts at the seat of injury, and endeavour to remove, as has been proposed, any portion of bone which he may find compressing the spinal chord, and thus treat the case on the same principle as he would a depressed fracture of the skull accompanied by symptoms of compression of the brain? To the solution of these questions we shall now briefly address ourselves in connexion with J. D.'s case, leaving out of view, for the present, the general treatment that should be adopted in fractures of the spine.

With regard to the first question, all authorities of weight are, with very few exceptions, agreed on the danger and impropriety of attempting reduction, when the fracture is situated in either the cervical or dorsal regions. Boyer has described a case in which a child suddenly expired under such an attempt. When the fracture has its seat in the lower portion of the spine, Sir Benjamin Brodie says, "that the attempt to effect reduction may not only be made with impunity, but that it may be successful;"* and he has recorded two cases in support of this assertion. As however the paralysis persisted in both cases, and as they appear to have ran the same course as many such cases have taken where no such treatment had been adopted, they have not been generally received by the profession as evidences in favour of the point now under consideration. Although some are still of opinion that, in every case of fracture of the spine with displacement, a reduction of the displaced parts should be attempted, yet the great majority of modern surgeons are, on the contrary, strenuously opposed to the employment of forcible extension in fractures of the bodies of the vertebræ, wherever situated; not only inasmuch as such attempts have hitherto failed in saving life, but moreover as such treatment would obviously have a tendency, as it had in Boyer's case, for instance, to inflict additional injury on the spinal chord, which, in nearly all these cases, has been found to have suffered from severe concussion or laceration, as well as from compression of blood or bone, or from the conjoint effects of both, as in J. D.'s case.

In respect of the second question, Heister,† a century since, laid it down as a rule of practice, that in the worst cases of fractures of the spine, "the surgeon must lay bare the fractured *vertebra* with a scalpel, or else remove such fragments as injured the spinal marrow." But it does not appear that either Heister or any of his cotemporaries, as far as we have been able to make out, had recourse to such a proceeding.

More recently (in the year 1814) Mr. H. Cline, Jun., proposed the operation of trephining or sawing away the vertebral arch, with a view of relieving the compressed spinal chord in fractures of the spine with displacement, and such an operation was not only performed by Mr. Cline with the utmost hopes of success, but his example was followed by Tyrrell, South, Wickham, Attenburrow, Holscheir, Smith, and Rogers. The operation, however, unfortunately proved unsuccessful in every case in which it was attempted.‡ Experience has, therefore, declared against Cline's operation, whilst pathology is opposed to it, inasmuch as innumerable *post mortem examinations*, conducted by impartial observers, have not only proved that in the generality of cases of fractures of the spine, as in J.D.'s, the chord is violently concussed or lacerated, as well as compressed, the usual consequences of which are rapid ramollissement, and subsequent disorganization; but they have likewise made it manifest that the chief pressure is, in the majority of these cases, not exercised by the vertebral arch, but, as in J. D.'s case, by the broken body of the lower vertebra projecting backwards, a part obviously, as Mr. Liston has properly remarked, "completely out of the reach of any operation whatever."*

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* Med. Chirurg. Trans., vol. xx. p. 159.

† Heister's Surgery, vol. i. p. 140, 1757.

‡ Sir Astley Cooper's name is intentionally excluded from the list of those who performed Cline's operation, for although Sir Astley commenced such an operation in a case in which there was supposed to be a fracture of the spine with displacement, the arch was not meddled with, as the case turned out to be merely a fracture of the spinous process of a dorsal vertebra at its root. Mr. South when referring to Cooper's case, says, "I saw the operation performed, but I do not recollect how the case terminated."—*Chelius' Surgery*, vol. i. p. 540.

In answer to the objections against Cline's operation, Mr. South, one of its most strenuous and distinguished supporters of the present day, says, "The only objection to the operation of trephining the spine is, that we cannot, previous to the operation, ascertain whether the spinal chord be simply compressed, or whether it be partially or entirely torn through, or whether the symptoms of compression result from the effusion of blood in the different situations above mentioned, neither of which, indeed, can be ascertained after the vertebral canal has been opened, unless the sheath be rent. If, however, this objection hold in regard to the fracture of the skull with symptoms of compression, for no one can certainly determine what mischief may be beneath the fractured bone, and even if it be seen, as occasionally it may be, that the membranes of the brain are torn, and a portion of the brain itself squeezed out, yet if the bone be depressed, and the brain labours under pressure, no one would hesitate to remove the bone in whatever condition the brain beneath might be expected to be found. This treatment of a compressed brain, with symptoms of compression, being that which is thought necessary by all surgeons of experience, it seems to me that the analogy is so close as regards compressed spinal chord, that the operation is not merely permissible, but is called for imperatively; and I fully agree with Jæger, that the earlier it is performed the better. The much dreaded subsequent inflammation I do not think is much to be feared; at any rate, it is never taken as an objection to trephining the skull. The great difficulty in the after treatment is the great irritability of the bladder from the highly alkaline state of the urine, which depends on the irritation of the chord, but which, I doubt not, might be counteracted."†

Mr. Liston, on the other hand, when discussing the different proposals for the removal of the pressure of the chord in fractures of the spine by surgical operations, says, "By these means, now generally and very properly looked upon as unwarrantable, effused blood could not be removed, nor lacerations repaired, while the chance of inflammatory action would be much increased."

Sir Benjamin Brodie, speaking of Cline's operation, says, "The question respecting such an operation seems to me to lie in a very small compass; if the whole, or nearly the whole, of a vertebra be driven forwards, the depression of the posterior part of it will, of course, occasion a diminution of the size of the spinal canal; but the removal of any portion of the vertebræ, which is accessible to an operation, will be of little avail, as the irregularity in the anterior part of the canal, made by the displacement of the body of the vertebra, must be the same after, as it was before the operation."

"If there be simply a fracture on each side of the spinous process, with a depression of the loose or intermediate portion of bone, of course there must be a corresponding diminution of the size of the vertebral canal; but as that canal is much larger than the spinal chord, which it contains, it does not follow that the spinal chord is really compressed, or that any material diminution of the symptoms would follow the elevation of the depression."

"But let it be supposed that the spinal chord is really suffering from pressure, it has been already shewn that a much less degree of violence than that which is necessary to occasion a fracture of the spine may produce concussion, softening, and ultimately dissolution of the spinal chord, with a train of symptoms much worse than those which arise from simple pressure. Now, no operation can be of the smallest advantage in this respect; but on the contrary, if it be necessary to apply the saw in the performance of it, the jar and disturbance of the parts which this must occasion is even likely to aggravate the mischief."

"If these views be correct, it is evident that the cases in which there are any reasonable grounds for the performance of the operation must be of very rare occurrence, and that even under the most auspicious circumstances it must be doubtful whether it may not be productive of harm rather than of good to the patient. Nor, as far as I am acquainted with the results, do the experiments which have been hitherto made on the subject lead to any more satisfactory conclusions. I am not aware that in any of the cases in which it had been performed, the operation has proved the means of preserving the patient's life, or even of relieving any of the more important symptoms."‡

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* Liston's Practical Surgery.

† See Chelius' Surgery, by South, vol. i. p. 541.

‡ Med. Chirurg. Trans. Vol. xx. p. 160.

STEEVENS' HOSPITAL.

Case of Dislocation of the Head of the Femur on the Os Pubis; with Remarks.

BY W. COLLES,

SURGEON TO THE HOSPITAL.

Peter Rourke, ætat. 15, was galloping a horse through a field in which a cow was lying down, when, on approaching the cow, she suddenly sprang up; he is not aware whether the cow struck him or if the horse fell, but he was rendered senseless. It was found that his right hip had been dislocated, and considerable force was used in efforts to reduce it, but all were ineffectual; he was then sent into hospital, where I saw him about twelve hours after the accident.

He was lying on his back, the knees together and drawn up; the thighs flexed on the pelvis; the feet were separated by a space of ten or twelve inches, and any effort to bring them together caused him pain; the tibia of the right side was not parallel to that of the sound side, but forming an angle with it; the right knee projected about one inch beyond the left; the axis of the femur, instead of going up towards the spine of the ilium, fell considerably within the point between it and the umbilicus; the upper part of the thigh seemed to have been pushed more in under the body nearer the mesial bone; on the outer side, below the pelvis, there was a concavity, instead of the full rounded outline of the sound side.

On applying one hand on each trochanter, the right was felt to be well marked, but much less prominent than the left, and to be at a much greater distance both from the spine of the ilium and the tuberosity of the ischium; the buttock was much flattened.

On passing the fingers into the fold of the groin, a hard round substance could be felt near the symphisis pubis; it was influenced by the limited motion of the limb; this was evidently the head of the bone pushing the vessels to its inner side.

Any effort to straighten the thigh caused him such pain, he seemed so frightened, and had suffered so much from the previous efforts at reduction, that I was unwilling to delay any longer, and am unable to give a decided opinion on the mooted question, as to whether in this dislocation the limb be lengthened or shortened when in the extended position.

Having satisfied myself and those about me of the nature of the accident, I proceeded at once to the reduction:—The patient was placed lying on the left or sound side; chloroform was administered; the parts being properly protected, a sheet was applied to the lower end of the femur, and entrusted to two assistants standing in front of the patient, to make the extension.

A sheet passing between the thighs was held by one assistant, standing behind the patient; he was to make the counter-extension. I then passed a towel round the thigh, and standing over the patient, while extension was being made, I raised the thigh upwards; while doing so, I perceived the thigh to resume its natural figure and form, and the foot which stuck up away approach its fellow, and although no snap or jerk was perceived, I concluded the reduction had taken place. On relaxing the forces, the limb retained its form, and on further examination, I found that it could be moved with ease in all directions.

This case suggests several important points:—1st. As to the cause of the accident we can form no decided opinion; but I would explain it by considering that on the horse suddenly swerving, the femur was fixed against the saddle, the body suddenly jerked back and rotated on the head of the bone, the weight was sufficient to throw the head out of the socket forward; and if this explanation suffices to account for it, we may infer the dislocation occurred before the body reached the ground, and the want of any mark or bruise on any part in the neighbourhood would tend to strengthen the conjecture.

Another important point for the surgeon to attend to is, in looking for the symptoms of dislocation described by authors, he must be certain that the limb before him is in the same position, with regard to the body, as that from which the authors drew their description, otherwise doubt and confusion would render his judgment hesitating and uncertain.

Here most of the symptoms differed from those given in books, especially with regard to the length of the limb, but this difference is easily accounted for by considering the different positions of the limb. The new position of the head of the bone is about one inch removed from the acetabulum in the anterior direction, but on the same horizontal level. When, therefore, the limb is extended and in the line with the body, the length of the limb is little altered; but when the limb is at right angles with the body, the head of the bone is one inch removed from the acetabulum, in the direction in which the limb lies; therefore this inch is added to its length. And this consideration of the point may give us another diagnostic symptom in cases of dislocation. We will find, on putting the limb in different positions its length will differ, because it moves from a point which is not the centre, and therefore the radii are not of equal length. Thus, in this case, if we found on extension the limb was nearly of equal length with the other, but if, bent at right angles with the body, it was one inch longer, we might infer that the head of the bone was one inch anterior to its natural centre position, but neither higher nor lower. The deviation of the axis of the limb from its natural direction, whereby it caused this concavity at the upper and outer part of the thigh, was here strongly marked, and showed clearly that the head of the bone was thrown considerably nearer to the mesial line; and had we straightened the limb and viewed it laterally, I have no doubt but that we would have found the axis here thrown considerably in front; this double deviation of the axes of the limb, viewed in front and laterally, would also materially assist us in ascertaining the precise situation of the head of the bone.

In this case I caused the extension to be made at right angles with the axis of the body, because the limb lay in this position, and the boy suffered much pain in changing its direction, and also because I recollected that a few weeks previously I had a case of a stout healthy man, who had a recent dislocation on the dorsum of the ilium, in whom the extension was made in the straight direction without producing much alteration in the limb, but on changing the direction and pulling at right angles, the bone was very readily reduced. From these and other considerations, I would, therefore, be inclined to make it a general rule, that in dislocation of the hip the forces should be used at right angles with the body, the patient lying on the sound side.

We are told that we are made aware of the reduction of the dislocation by a peculiar snap or jerk, evident sometimes both to the ear and touch, and that the more recent the dislocation, the more strongly marked this sensation will be perceived. In this case none of the assistants, who were medical students, were aware of such, nor did I, who was pulling in a different direction, perceive it. I should, therefore, think we ought not to place much reliance on this as a necessary sign of the completion of the reduction; and I think I have seen some cases in which a severe extension was kept up for some time after the bone appeared to have been reduced, the surgeon anxiously expecting this jerk as necessary to satisfy him as to the success of the operation.

SIR PATRICK DUN'S HOSPITAL.

Case of Diptheritis successfully treated by Chlorate of Potash.

BY AQUILLA SMITH, M.D.,

PHYSICIAN IN ORDINARY TO THE HOSPITAL.

Maria Groves, a sempstress, aged 25, was admitted into Sir Patrick Dun's Hospital on the 17th of May, 1855. When visited on the 18th she complained of pain in the epigastric and left hypochondriac regions, attended with nausea and dyspnœa; the pain in the epigastrium was aggravated by pressure; her tongue presented a remarkable appearance, the dorsum and apex being of a bright reddish-brown colour, like a ripe arbutus berry; the papillæ were elevated and rather dry, the under side of the tongue was coated with thick curd-like flakes, particularly at each side of the frænum; the gums were swollen and red, as if the patient had been under the influence of mercury, but there was no mercurial fœtor; at the base of the gums and inside of the under lip there was a large patch of white exudation, with slight erosion of the mucous membrane. She complained of some pain in deglutition, particularly in swallowing hot drinks; her voice was feeble and husky, and the fauces could not be inspected in consequence of the pain caused by the attempt to open her mouth; there was no tenderness along the trachea, nor enlargement of the submaxillary glands; pulse 108, small and compressible, great thirst, skin hot and dry, bowels regular.

Her illness had commenced four days previous to her admission, with a severe rigor, followed by intense headache and vomiting, which was succeeded by diarrhœa.

According to her own statement her previous health had been good, with the exception of occasional irregularities in the menstrual discharge, being either excessive or deficient. Ordered eight leeches to the epigastrium, one scruple of chlorate of potash, in solution, every fourth hour, and milk and lime water for drink.

19th.—Feels better; skin moist and cool; tenderness in the epigastrium diminished; tongue moist and somewhat paler; thirst diminished; voice husky, but no tenderness about the trachea, nor any affection of the lungs; pulse 100. To continue the treatment.

20th.—Perspiring freely; tongue moist and paler; pulse 92; the exudation on the under side of the tongue fissured and partially detached at the edges; voice hoarse and feeble. To continue the medicine.

21st.—Pulse 80; tongue moist, and of a healthy colour; the curd-like exudation has entirely disappeared; skin moist; no epigastric tenderness nor thirst; voice clearer, bowels confined. To continue the medicine, and to get an enema.

22nd.—Better in every respect; pulse 72; to take the chlorate of potash every sixth hour.

Her recovery was progressive from this date, and she left the hospital on the 25th at her own desire; her voice was perfectly natural, and her only complaint was that she felt rather weaker than she was before her illness.

Acute idiopathic diptheritis occurring in an adult in good health previous to the attack is a rare affection. The thickness of the exudation on the under side of the tongue was a remarkable feature in this case, and the constitutional disturbance was greater than might be expected from the apparent limited extent of the disease.

I was induced to try the effect of the chlorate of potash in consequence of the success which has been attributed to it in stomatitis; and the complete cure of the patient who was only one week in hospital, may be attributed to the chlorate of potash, as no change was made in the treatment which was prescribed at my first visit.

MEATH HOSPITAL.

Case of Idiopathic Inflammation of the external Jugular Vein; Albuminuria; with Observations on the use of Turpentine in Internal Inflammation.

BY DR. LEES,

PHYSICIAN TO THE HOSPITAL.

Reported by MR. J. H. WALSH.

Eliza Messer, æt. 19, admitted into the Meath Hospital, February 22nd; stated that about a week previously she got a severe fall on the back while carrying a can of water on her head; she was a little stunned, and immediately after experienced a stinging pain underneath the left breast, which did not trouble her much at first. However, about six days after she was seized with rigors, frequent vomiting, cough, and pain in the left side, aggravated when she coughed and during inspiration.

On the 23rd her countenance was flushed and anxious; respiration hurried, 46; pulse 120; skin hot and dry; expectoration rusty, though not viscid; tongue clean and moist.

On examination there was a slight trace of dulness anteriorly beneath the right clavicle and in the right axilla; in both those regions respiration was rough, with fine crepitus at the end of inspiration. She complained of pain in the præcordial region, increased by pressure on the epigastrium; circumscribed friction was detected corresponding to the apex of the heart, and there was also friction under the left axilla. The posterior regions of the lungs were unaffected.

To be put under the influence of mercury; to have a mucilaginous expectorant mixture, and flannel vest, with tea diet.

The following night she was suddenly attacked with violent dyspnœa, cough, pain in the left side, and rapidly passed into a state of collapse. She was extensively dry-cupped, and got turpentine in ʒss. doses every second hour, given alternately with punch.

Next morning she expressed herself much relieved by the turpentine. Her face appeared more anxious and congested than the previous day; pulse very small, intermittent, and quick; respiration 60. Increase of dulness accompanied with bronchial respiration under the right clavicle, fine crepitus below the right axilla; friction continues at the left side; ordered two blisters, one to be applied under the right clavicle, the other under the right axilla.

℞. Calomelanos gr. xii.
Hyd. c. Cret. gr. xii.
P. Doveri. gr. xii.
P. Ipecac. gr. ii. Ft. Pil. xij.
St. i. secundis horis. Vini ℥viii. punch.

After this treatment she felt much better, the sputa lost its rusty colour, and assumed a bronchitic character; and the right lung became resolved, but the pulse continued at 120, and she had occasional attacks of violent spasmodic cough. The mercury, &c., was gradually stopped.

On the 4th March her feet became œdematous. Her urine coagulated on applying heat and adding nitric acid. On the evening of the 8th, she was attacked with severe abdominal pain, great dyspnœa, and dry retching. Next morning her countenance appeared livid and anxious, respiration 60; pulse quick, small, and intermittent, could not be reckoned; decubitus on the right side; before this she invariably lay on the left side. On examining the abdomen, Dr. Lees found that the liver was greatly enlarged, extending to the umbilicus, and over into the left hypochondriac region. It was not very tender on pressure. Ordered pills of hyd. c. cret. ipecac. et Doveri pulv., a blister to the right side, poultices to the abdomen, mercurial ointment afterwards to be rubbed to the abdomen.

9th.—There was friction perceptible in the region occupied by the enlarged liver; tenderness not increased, respiration 44; pulse 132.

On the 10th, complained of pain in the left side of the neck; the left external jugular vein was indurated, tender, and felt like a knotted cord. She soon after felt pain in the shoulder, which became swollen; the œdema extended down the arm as far as the hand; the pulse continuing at 132; the left side of the neck and breast was swollen; the superficial veins here were distended, of a dark blue or purple colour, ramifying over the surface of the pectoral muscle.

The veins on the left side of the forehead, and of the eyelid of that side, were also greatly distended. She was now put on stimulants, but soon sunk into a low typhoid state, and died quietly in a few days, but we unfortunately could not get an examination of the body. This case is worth recording, chiefly from the occurrence of inflammation of the jugular vein, as I am not aware of any similar case, and though we had no examination after death, yet the physical characters of inflammation of the vein during life were so well marked, as to satisfy me of its presence. It would have been satisfactory to have ascertained the condition of the pulmonary artery and its branches in this case, as Hasse observes, that "coagulation of the blood, consequent upon phlebitis, has been observed most frequently in these vessels;" and though the veins of the great circulation, especially those of the head and neck, are sometimes greatly congested in pneumonia, yet the distention of the veins in this case being limited to the left upper extremity, proves that the obstruction was confined to the veins of that side. The occurrence of frottement in the pericardium and pleuræ, and finally in the peritoneum covering the liver, was also highly interesting, both from the coexistence of albuminous urine and the subsequent occurrence of phlebitis, showing that some morbid influence was pervading the system, and exciting there various inflammations. It is probable that the true pathology of the case was,—First, pneumonia with inflammation of some of the veins of the lung, which is most likely to occur when the upper lobe of the lung is attacked. Second, inflammation of the pleura, pericardium, and peritoneum, consequent on the phlebitis. The diffuse inflammation of the shoulder-joint and arm confirms me in this opinion, as also the presence of albumen in the urine, although I could not detect any pus in it. The sudden attack of dyspnœa and pain in the left side, with the rapid collapse, was, probably, caused by the pneumonia assuming the phlebitic character; and the efficacy of the turpentine was very remarkable, as she appeared to be dying when it was given to her, and expressed herself relieved by every dose of it. I feel convinced that the value of this remedy, in certain forms of inflammation, is not properly appreciated; and though many years have elapsed since Mr. Hugh Carmichael, of this city, first called the attention of the profession to its use in cases of iritis, we are still much in the dark with respect to its action in other varieties of inflammation, and I trust that those practitioners who have used it in such cases may be induced to favour the Dublin Hospital Gazette with any facts and observations bearing on its use.

Remarks on Iodised or otherwise Medicated Collodion as an External Application.

By CHRISTOPHER FLEMING, M.D., M.R.I.A.,

SURGEON TO THE RICHMOND HOSPITAL.

The great value derivable from the external application of iodine and its different preparations is generally admitted. In many cases, unnecessary here to specify, a fluid form is to be preferred, and the more circumscribed the specific action of the remedy, and the more rapid the effect produced, the better. Repeated applications are often as troublesome as they are annoying, and hence the solution of a concentrated preparation or one, sufficiently so, is desirable. The tincture, or the compound tincture of iodine, even in the atomic proportions, as noted by Dr. Todd, of London, in the "iodine paint," does not effect this object except in special situations. I contemplated the localized concentration of the remedy, and it occurred to me that the combination of the compound tincture of iodine with the solution of gutta percha in chloroform, with which it is perfectly miscable, would possess the requisite advantages. This admixture was fully effected, but I found that the rapid vaporization of the chloroform rendered it, almost instantaneously in some instances, a solid, tremulous mass, unfitted and unmanageable for the object in view. Bearing in mind the very valuable preparation of the "vesicant collodion," furnished to me by Mr. Oldham, it struck me that the combination of collodion with iodine would answer all practical purposes, and as far as I have as yet been enabled to ascertain, the most satisfactory results have arisen from such—rapid action of the remedy, even from one application, is superinduced, its requisite limits are accurately circumscribed, and a slow, but decided and persistent cutaneous irritation is secured, accompanied with compression, which has appeared to me to be very beneficial.

This application is in some cases painful for a time, and care is requisite as regards the relative proportions of the ingredients. Dr. Aldridge has been kind enough to make some experiments on the quantity of iodine soluble in collodion, and finds that, although a drachm of solid iodine will readily dissolve in an ounce of that fluid, yet that the crystallization of the iodine interferes with the drying of the collodion, and in consequence of the iodine in contact with the skin being prevented from evaporating by the overlying pellicle of collodion, it is likely that a much smaller quantity of iodine will answer all purposes. My impression at present is, that the proportion of ten or twenty grains to the ounce will suffice as an external application, and that even of this strength it should not be indiscriminately applied. A much less proportion, say of five grains to the ounce of collodion, forms a highly stimulating application when the skin is very delicate, and in particular stages of chronic suppuration, &c., will be found a most efficient remedy, and to the "vesicant collodion" the addition of even a less quantity of iodine imparts considerable activity, as is well known to veterinary surgeons it does, when mixed with their blistering applications. Dr. Aldridge considers the paper collodion the better menstruum, because it forms a tougher skin. When the skin, however, is very soft and yielding, this toughness may be productive of a traction not free from annoyance. This use of "iodised collodion" will be found extremely manageable in very many forms of tumours, and with or without iodine other agents can be combined with collodion of equal efficacy in reproducing their specific action. Thus, several of the alkaloids are soluble in ether, and, therefore, in collodion, and can be applied locally through its agency. Whilst this paper was passing through the press, Dr. Aldridge was kind enough to prepare for me a solution of atropia, in the chloroform solution of gutta percha; this alcaloid formed almost instantaneously a transparent and almost colourless solution in the menstruum, without the aid of any acid. I painted his upper eyelid with some of this solution, and in a very few minutes the pupil was manifestly dilated. Through Dr. Aldridge I contemplate solutions of coneia and other alkaloids in collodion, and in chloroform, with similar objects.

At the same time I may remark, that considerable, and perhaps, for aught I know, equal benefit is derived from the combination of concentrated solutions of extracts of those agents.

The best mode of applying these remedies is with a camel's hair brush. It should be rapidly passed over the part, as a thick varnish very quickly forms, and it is curious enough to watch the effects of the rapidly evaporating iodine.

Case of Oxaluria.

BY B. WILLS RICHARDSON, F.R.C.S.I.

Although the presence of oxalate of lime in the urine is, in a considerable number of cases, accompanied by serious derangement of the general health, yet, that it may also exist in this excretion without any such symptoms cannot be denied.

Dr. Golding Bird found traces of this salt in the urine of persons exempt from any manifest disease, and he looked upon it as a physiological condition; but when it was found existing in large crystals, he considered it indicative of a state of system strictly pathological.*

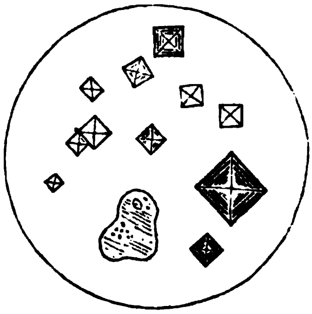
The following case, therefore, cannot be devoid of interest, because a considerable quantity of both large and small crystals, and not mere traces, of the oxalate existed in the urine, without any special symptom to lead me to suspect its presence; if we except a pain which occasionally attacked the neck of the bladder. It was this symptom which induced me to examine the urine. At the same time that I was attending this gentleman, his brother was under my care for a fit of the gout, and he too complained of a similar pain in the region of the cervix vesicæ, but his urine was free from the crystals of any salt.

I was at first led to consider that this pain depended upon irritating urine in both cases, but as the oxalate of lime has completely disappeared from the urine of the former, and both are at present in apparently good health, the pain, however, still occasionally attacking them, I am now disposed to consider it the result of some idiosyncrasy.

The former gentleman consulted me for a small and superficial ulceration chiefly limited to the septum narium, near the point of the nose. In the course of conversation he mentioned that he was sometimes disturbed at night by a pain which he referred to the neck of the bladder; this occurred about once a month, and not unfrequently there was an interval of six months between the attacks, which rarely lasted more than a minute or two. His appetite is good, tongue clean, bowels and pulse regular, skin natural; he is not emaciated, and he felt so well in his general health, that I had some difficulty in persuading him to take a course of alterative medicines. He leads a most active and temperate life, and at present resides in the country.

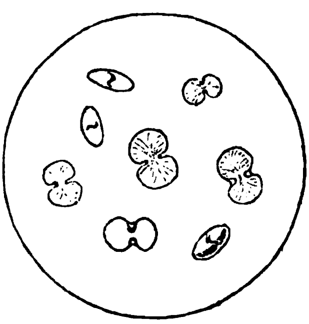
The urine was acid, and on examining it with the unassisted eye, I found it clear and free from deposit, but with the microscope I ascertained that great numbers of octahedral crystals of oxalate of lime were diffused through it. Fig. 1 represents some of the crystals with an epithelial scale, all of which existed in a single drop of the fluid.

Fig. 1.



Wishing to preserve some of the crystals as microscopic objects, I filtered the urine through bibulous paper, and thereby procured a good many dumb-bell crystals of oxalurate (?) of lime.

Fig. 2.



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* Urinary Deposits. Fourth edition, London, pp. 210, 211.

The oval bodies seen in this figure seem to me to be dumb-bells seen sideways.

Notwithstanding there was no apparent constitutional disturbance in the above case, still I think we must attribute the temporary presence of the oxalate in the urine to some transitory derangement of the assimilative functions, the result, perhaps, of anxiety of mind connected with his professional pursuits. I should have before mentioned that he had not taken any article of diet that is known to cause the presence of this salt in the urine.

The merely temporary presence of oxalate of lime in the urine cannot be classed in the same category with those cases, also unattended by symptoms, although it persists in the urine, the persons thus affected following their usual avocations, which have led some to consider its presence in this excretion of no consequence; but as Dr. Golding Bird truly observed, "If this kind of reasoning be admitted, the existence of albumen or blood in the urine might be regarded of no importance, because we often meet with patients affected with this very condition, and yet are so free from apparent indisposition that we are often unable to persuade them to take care of their health until the disease indicated by the state of the urine in question proceeded to an incurable condition."*

In cases of oxaluria, the crystals of the oxalate and oxalurate of lime frequently replace each other, but in the one I have given they coexisted in the same specimen of urine.

Gluten Bread.

By JOHN ALDRIDGE, M.D.

To the Editor of the Dublin Hospital Gazette.

Sir,—Perhaps the publication of the following form for the preparation of gluten bread may save others the time and trouble I have myself experienced, in endeavouring to produce an agreeable and suitable edible. Whatever theory we may entertain as to the essential nature of diabetes mellitus, it is now generally admitted, as a practical fact, that benefit is derived in this disease from the limitation of the saccharine elements of food to the smallest possible quantities. As bread of some kind can scarcely be omitted from any system of alimentation, it is, therefore, desirable that we should be capable of making a variety which, containing but very little sugar or starch, should still be nutritious and palatable. At Bewley and Evans' we are frequently required to prepare a gluten bread, and the following is the formula which, after many experiments, we have found to yield the most advantageous product:—

℞ Fresh moist gluten, 24 oz.
Bicarbonate of Ammonia, ʒiij. grxij.
Common salt, ʒ iss.
Powdered carraway, 48 grs.
Wheaten flour, 4½ oz.
Powdered bran, 1½ oz.
Salt butter, 4 oz.

The above quantities yield 24 oz. of bread, when baked. It should be baked in small and flat circular tin pans, placed on a moderately heated hot-hearth.

The only assistance that I derived from books in the construction of the foregoing formula, was contained in the following passage in *Bouchardat's Manuel de Matière Médicale*, 1846, p. 515:—"Avec 80 de gluten, 20 de farine, et une petite quantité de levûre de bière, j'ai fait préparer du *pain de gluten* qui a rendu de grands services aux malades affectés de glucosurie." I need scarcely say that this process yields a leathery, tasteless mass, nearly impossible to masticate.

To render small quantities of bread light and spongy, I prefer bicarbonate of ammonia to fermentation by means of yeast, as without great care the latter is liable to get sour; and the bread ought to be made fresh from day to day. The addition of butter is essential to make the bread easy to masticate,—to eat short,—as, I believe, the technical expression is.

Second best flour, at about three shillings per stone, is that which I employ for obtaining the gluten. This is to be made into a stiff paste with cold water, and then kneaded with the hands under a current of water, on a slanting board placed in a ten gallon black crock, until starch can no longer be detected in small portions (taken from different parts of the mass) by tincture of iodine. The stone of flour yields from three and a-half pounds to four and a-half pounds of gluten.

I am, Sir, yours, &c.,

John Aldridge.

8, Lower Sackville-street, June 8th, 1855.

SELECTIONS FROM BRITISH AND FOREIGN JOURNALS, &c.

Congenital Dislocation of both Elbow-joints.—M. Chaissaignac presented to the *Société de Chirurgie* of Paris an adult in whom this lesion existed. The upper extremities of both bones of the fore-arm were much enlarged; the olecranon was expanded; the head of the radius, which was likewise hypertrophied, was displaced forwards and outwards.

The deformity, which was perfectly symmetrical, dated back to early infancy. At ten years of age the patient himself first noticed that the motions of the elbow-joints were impaired. From these circumstances, M. Chaissaignac believed that a double congenital dislocation existed.

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* Urinary Deposits. Fourth edition, p. 240.

A lengthened discussion followed.

M. **Morel Lavallee** admitted that the radius was displaced and the ulna enlarged; but from perceiving a rough crepitation when the joint was moved, he believed that these changes were the result of *dry arthritis* (rheumatic?). He had seen a case precisely similar, in which a foreign body likewise existed in the joint. Had this complication not been absent in the case before them, the identity of the two would have been perfect.

M. **Verneil** believed the case to be one of congenital dislocation, from the symmetry of the lesion, its dating back to an early age, and the rarity of dry arthritis in early life. He believed it had never been met with in the child, whereas the deformity of the elbows, in the case under consideration, had been observed during childhood.

M. **Honel** doubted the congenital nature of the lesion. In the true congenital luxation, the upper end of the radius, instead of being hypertrophied, is, on the contrary, much atrophied.

M. **Giraldes** believed it was a chronic rheumatic affection. He was convinced that a great many reputed congenital luxations were, in reality, *pathological luxations*. In Ireland, where rheumatism is extremely common even in the young, this error has certainly been made more than once.

M. A. **Richard** thought a mere symptom had been mistaken for the disease itself. The luxation of the radius was but a secondary matter. The primary lesion was evidently an enlargement of the upper end of the ulna which had displaced the radius outwards (!)

M. **Verneil** maintained his former views of the case; and in reply said, that he did not agree with M. Honel that atrophy of the head of the radius was an absolute rule in congenital luxation. It was possible to confound such cases with the effects of chronic rheumatism; but in order to show that this disease had any influence in the case in question, it should be proved that this patient had been subject to rheumatism; the fact of the patient only becoming aware at the age of ten years, that the movements of the elbow-joints were limited, is not opposed to the idea of congenital lesion; for it is by no means unusual to find the signs of luxation in this class of cases, remaining undeveloped or unobserved for a long time after birth.

The existence of crepitus did not prove that all the changes depended on disease. It is very common for malformed articulations at a later period of life, to become the seat of chronic arthritis. This has been observed in cases of congenital luxations of the femur.

[Notwithstanding all that has been written on congenital luxations of the elbow, the members who took part in this discussion do not really appear to know enough of the subject to be competent to decide on the question at issue. Considering how much Irish surgeons have contributed to our knowledge of the pathology of chronic rheumatic arthritis and congenital luxations, M. Giraldès' remark that errors are often made on this subject in Ireland is really provoking. The truth is, that for a long time congenital luxations were confounded with those the result of accident, by French surgeons. And we would here refer to the remarkable case described and delineated by Cruveilhier, as an example of accidental luxation of the wrist joint, which was, by Mr. Adams, ably shewn to be an example of congenital luxation. Mr. Adams was accordingly the first to determine the pathology of that lesion. Of the pathology of chronic rheumatism, and its influence in obscuring the differential diagnosis of injuries in certain articulations, French surgeons were, by their own admission, wholly uninformed. The reviewer who noticed, in the *Gazette Medicale*, the account of that disease published by Mr. Smith in 1835, speaks of it as "une affection, presque entièrement inconnue de nos chirurgiens."*

The subject of congenital dislocations of the head of the radius has of late years received from pathologists, more especially in this country, much attention; and if ignorant of the researches of Irish surgeons, the members of the *Société de Chirurgie* should at least be familiar with the labours of the distinguished men of their own country.

Dupuytren, it appears, was the first to describe congenital dislocation of the radius, more particularly the dislocation upwards and backwards.

Cruveilhier (Livraison ix.) has delineated the morbid appearances in two similar cases, but regards them, as well as the case recorded by Dupuytren, as old luxations left unreduced. Mr. Adams has in this instance again corrected the errors of the French pathologist, and has conclusively shewn that these cases are really examples of congenital luxation.†

Resuming our historical sketch of this subject, we find further illustrations of this lesion brought forward by Mr. Adams in 1840. The pathology of the displacement forwards and upwards was now determined. Mr. Smith has since added several new varieties of this lesion, as, for example, the luxation upwards, and the luxation directly forwards. These cases will be found in the Reports of the Pathological Society.*

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* Smith on Fractures, p. 127.

† *Vide* article Elbow, Todd's Cyclopædia, part ix.

The two grand distinguishing features of congenital luxation of the head of the radius, under whatever variety it may be presented to us, are not even alluded to in the discussion above detailed. These are,

1st. The remarkable *elongation of the neck of the radius*, in consequence of which the summit of the radius passes beyond the lower extremity of the humerus, and comes to lie on the same level with the top of the olecranon.

2nd. The total absence of the capitulum of the humerus, and increased development of its trochlea.

The principal points of interest in such cases are thus clearly defined by Professor Smith in the communication to the Pathological Society already alluded to. "Upon reviewing the history of the cases and preparations which were now placed before the Society, it would be seen that there was one character common to them all, namely, that no matter in what direction the displacement of the head of the radius might have occurred, in every instance the capitulum of the humerus was either partially or altogether deficient. It appeared reasonable, therefore, to consider this arrest of development as the primary lesion, the essential character of all these malformations of the radio-humeral articulation. The *abnormal length* of the upper end of the radius was most probably consequent upon this malformation of the humerus, and was another feature which almost all these cases presented in common."—EDITORS *D. H. G.*]

Secondary Inflammation of the Joints.—At a meeting of the Harveian Society, Mr. Coulson read a paper on these inflammations, which, he said, occur during the course of other disorders. They are not accidentally associated with them, but evidently connected by some peculiar link with the primary affections, as is shown not only by the peculiar characters of the secondary diseases, but by the frequency of their occurrence during the course of the primary affection. The term "secondary inflammations" is applied by the author to these diseases of the joints in order to leave open the question of their nature; but he is disposed to affirm that more accurate and extensive investigations will enable us to ascend one step higher, and trace them all to blood-poisoning. Having related the details of a case of gonorrhœal rheumatism, the author observed that the points of most interest in connexion with these secondary inflammations of the joints are:—1st. What are the primary diseases with which they are allied? 2nd. What is the nature of these secondary affections? are they of rheumatic origin, as the name given to them generally would lead us to suppose, or are they specific inflammations? 3rd. If specific inflammations, does each group acquire its specific character from the primary disease on which it depends, or can we trace the whole class of secondary joint affections to one general law, giving to all the same character independently of the particular disease from which the group appears to originate? According to the author, the chief primary diseases or conditions with which these secondary inflammations are connected may be divided into seven groups. They are—1. The puerperal stage, giving rise to puerperal rheumatism. 2. Exanthemata, especially small-pox and scarlatina, producing inflammations of the joints generally attributed to rheumatism. 3. Injuries to the genito-urinary apparatus of the male. 4. Gonorrhœa, followed by so-called gonorrhœal rheumatism. 5. Animal poisons, especially that of glanders. 6. The state of new-born children. 7. Injuries, amputations, &c., followed by purulent inflammation of the joints. In speaking of puerperal rheumatism, the author pointedly alluded to the error committed by many writers, who join the name of rheumatism to the articular affections which occur in puerperal females. These differ from true rheumatism in every essential particular—in the general and local symptoms, in the course, in the result, and in the effects of remedies. The general symptoms of acute rheumatism are inflammatory; those of puerperal arthritis are eminently atonic. Besides this, the general symptoms which accompany the articular affections of puerperal women do not belong to the joint diseases; they do not correspond to any known class of fevers, but they depend on a peculiar state, which has been traced to purulent infection of the blood. The general signs of the rheumatic diathesis are absent in these and other cases of an analogous kind—a circumstance which should be decisive of the question. The course of the two affections is different; although the local symptoms are much less violent in puerperal arthritis, it runs a much more rapid course than rheumatism, however acute. The local symptoms are altogether disproportional to the effects produced on the joint—supposing the disease to be rheumatism. Acute rheumatism hardly ever ends in suppuration; whereas effusion of pus within the cavity of the joint is the main character of the puerperal disorder. The results are different; for rheumatism of the joints, *per se*, never proves fatal; whereas nearly all the cases in puerperal women terminate in death. Remedies, therefore, produce no effect in the latter diseases; while rheumatism, in all its forms, is amenable to treatment. Puerperal arthritis may occur after parturition, or after abortion, during the early period of pregnancy. It may, or it may not, co-exist with puerperal fever; and hence the great diversity of general symptoms observed in different cases. Sometimes the articular disease is merely one of the effects of uterine phlebitis, the general symptoms being those of purulent infection of the blood. In other cases, we have uterine phlebitis followed by puerperal fever, and complicated with purulent absorption. Here the two orders of general symptoms—viz., those of puerperal fever and those of purulent infection co-exist. The secondary puerperal inflammations of joints have a tendency to run a very rapid course. The purulent effusion sometimes occurs within a few hours after the first symptoms of pyæmia. Several joints are attacked in succession. The cartilages are apt to suffer, being often softened, abraded, or absorbed. Effusions of pus often exist around the joint, and in the centres of the muscles; and the limb is frequently affected with an œdematous swelling, which much resembles phlegmasia dolens. In the great majority of cases, the inflammation is purulent; more or less effused within the cavity of the joint, and the synovial membrane is injected, though it may happen that the injection is very slight. In other cases, the purulent deposits take place outside the joints. In a few cases, the articular inflammation is non-purulent, although deposits of pus are formed in the neighbouring muscles. Finally, in some cases, the inflammation of the joints is simple and slight, terminating, of its own accord, in a few days. The next group noticed by the author is that connected with injuries to the genito-urinary system of the male. The secondary affections of this group are usually purulent, though often simply inflammatory. The pus deposits exist very often exterior to the joint, as often perhaps as in the joint itself. The course of these inflammations is irregular; in some cases they are very acute; in others, the series of attacks, though sub-acute, is spread over a long period of time. Here the pyæmia appears to be of a chronic kind; and the secondary articular affections may terminate favourably. It is remarkable that many of these diseases appear to be produced by mere irritation of the urethral membrane; but Mr. Coulson thinks that, in such cases, ulceration or phlebitis has existed in some part of the genito-urinary system, the irritation merely acting as an exciting cause of absorption of the pus. The articular disease, improperly called gonorrhœal rheumatism, is next considered; after which the author notices the well-known group connected with wounds and injuries. Inflammation of the joints connected with blood-poisoning, from the introduction of certain animal poisons, is then described. Mr. Coulson connects this group with glanders, the only poison whose effects on the joints have yet been studied. The articular inflammation which appears during the course of glanders is generally purulent, though sometimes simple. Its principal character is chronicity; the blood seems to be affected by many successive poisonings, and hence, perhaps, the reason why the articular inflammation is occasionally simple, although the primary disease is essentially purulent. The secondary joint diseases connected with small-pox might be placed in the preceding group; but, in compliance with received opinions, the author classes them under the exanthemata. These variolous inflammations are sometimes purulent; but they are commonly slight, and terminate spontaneously in a few days. Scarlatina is also attended by a peculiar inflammation of the joints, which has latterly attracted much attention, although its history is still obscure. Many physicians persist in regarding it as rheumatic; but while Mr. Coulson admits that epidemic rheumatism may co-exist with epidemic scarlatina, he believes that most of the cases which have been described as rheumatism are really secondary inflammations of the synovial membrane, of the kind described in this paper. From these considerations, the author is disposed to infer that the seven groups of secondary inflammations of the joints, which he has described, may be all referred to one specific cause—viz., infection of the blood. Moreover, he attributes five out of the seven to purulent infection of the blood; while he attributes variolous and gonorrhœal inflammations to the same cause, though with a certain reserve, as not yet fully established. The circumstance of these inflammations being often simple, Mr. Coulson says, is not conclusive against their connexion with blood poisoning, because the articular inflammation consequent on pyæmia is not invariably of a purulent nature.—*Lancet.*

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* *Vide Quarterly Journal*, February, 1852, p. 209.

On the Nature and Treatment of Croup. By Dr. Hönerkopf (*Journal für Kinderkrank.* 1855. B. XXIV. P. 172.—The chief object of this paper is to call renewed attention to the efficacy of sulphate of copper in the treatment of croup. The little favour it has hitherto met with he believes due to its being considered a poisonous substance, and one, from its irritating nature, ill-suited to an inflammatory disease. As to the first point, he says he has employed it in 90 cases without any ill effects, although he administered 2846 grains, or an average of 31½ grains per case. In 15 cases the average reached 77 grains. One child took in eight days 216 grains, or a daily average of 27 grains, and another 40 grains per diem for three days. No evil consequences resulted in any case, and convalescence was much more rapidly established than after antiphlogistic treatment. In treating the poor, who are quite unable to pay for leeches, the economy of this plan is also worth consideration. In the author's cases the duration of the treatment varied from 1½ to 2 days upon the average.

As to the other point, Dr. Hönerkopf reviews the series of symptoms, in order to show that croup is not an inflammatory disease; but here we need not follow him, merely observing that when he states the effusion of pseudo-membrane is no essential feature of croup, and only occurs in about half the cases, that he must include in his 90 cases, several that others would characterize as false or spasmodic croup, a far more curable affection. The great number of cures he met with, (77 in 90 cases) also confirms this view. From some trials he has made the author is disposed to believe, that small doses of the copper, given for a considerable period to children who are much predisposed to, or who have already suffered from croup, may exert some prophylatic effect. As a curative agent he employs it solely, giving a solution of from 6 to 8 grains in 1 oz. of distilled water, from a tea-spoonful to a half or whole tablespoonful. The ease or difficulty with which vomiting is produced regulates the frequency with which the dose must be repeated; for the torpor of the nerves of the stomach increases with the progress of the disease, and the difficulty of producing vomiting becomes a measure of the severity of the affection. While at the beginning, in slight cases, and towards the decline of the disease, small doses of emetics suffice, much larger doses are required when the malady has continued some time, or is very severe; and after a certain point vomiting cannot be produced at all. A dose is given every 10 or 15 minutes, for four, six, or even eight times, until the more violent symptoms are abated, the quantity being regulated by the severity of the case. Occasionally such improvement is observed after the very first dose. The cough is first less troublesome, there are less anguish and dyspnœa; and, lastly, the croupy sound is exchanged for a mucous râle. The drug is now given in smaller doses every 20 or 30 minutes, and at still longer intervals. In bad cases, if even slight croupy sound remains, it is still continued every 2 hours, as a relapse is to be feared on the next night. It is also desirable that the patient should not be left without the means of meeting a recurrence, even on the second or third night; but a couple of doses will then usually suffice.

If in very bad cases we can scarcely perceive any change in the croupy sound in twelve or more hours, we must not yet despair, for the improvement is often sudden and unexpected. When the other symptoms have improved but this tone remains, we must never relax, for the enemy only sleeps, and may break out again with renewed vigour. Everything depends upon the energy of the practitioner, who must at first see the doses forced down the child's throat, or they will be neglected, and especially as the child's condition and the friend's carelessness require watching the next evening or two, when relapse is so common. Although vomiting is not the object of the copper, and excited by other means has not like efficacy, it is the measure of its success. How far the remedy has to be carried depends upon the amount of success. A single grain exciting vomiting once or twice may suffice in slight cases, while in others 100 grains producing vomiting from 80 to 100 times may be necessary in others. Sometimes when the excitability of the stomach is quite exhausted, and large doses fail to excite vomiting, this may be roused again by giving 2 grains of musk every few hours.

We have already said that cases of false croup must have been included among the author's 90; and we may here reproduce M. Guersant's summary of the various forms of angina. He observes that, prior to his father's and M. Bretonneau's writings upon the subject, pseudo-membranous angina, croup, and other affections were confounded together. Those writings and daily practice show that there are five distinct species of angina.

1. *False croup* (stridulous laryngitis) which comes on suddenly and terminates as a cold, not producing false membranes, and being almost always curable. 2. *Pharyngeal diptheritis* is characterized by false membranes lining the tonsils and pharynx, to which they are usually confined. It is generally curable by caustic applications. 3. *True Croup* (pseudo-membranous laryngitis) is characterized by the development of false membranes in the larnyx. These may be formed primarily in and confined to the larynx, or they may spread from the pharynx or trachea. This diptheritic lesion, which is usually of slowish formation, and sometimes met with more than once in the same subject, is, so to say, localized, and produces death by asphyxia. 4. *General diptheritis*, angina maligna. The true diptheritic poison, which kills the patient just as glanders kills the horse, is an insidious and contagious disease, and is indicated by great prostration, enlargement of the cervical glands, and the deposition of false membranes in the nasal fossæ, the pharynx, sometimes the larynx and bronchi, the vulva, and on blistered surfaces. Neither this disease nor croup causes any gangrenous odour. It does not kill by asphyxia, so that tracheotomy is here contra-indicated. The disease is usually fatal, the patient sinking exhausted, and tonics, with cauterization of the surfaces, are the only means that offer any hopes of benefit. 5. The *true gangrenous angina* destroys any of the parts it attacks, as the tonsils, the uvula, the velum or pharynx, and may complicate any other angina, just as all gangrenes may complicate or terminate all inflammations. This angina is far rarer than any other, is not accompanied at first by false membranes, and always ends fatally.—*Gazette des Hôp.* 1855. No. 36.

Recent Examination of the Human Bile. By George Kemp, M.D., Guernsey.—A boy was accidentally shot in this Island by a rifle ball, and died almost immediately from hæmorrhage.

I received the gall-bladder, with its contents, about twenty-four hours after the accident, the "ductus choledochus communis" having, of course, been carefully tied up.

The gall-bladder, with a small portion of the liver attached, was in a most remarkable state of preservation; and, struck with the freshness of the blood-coloured cellular tissue when it arrived, I was induced to wash off a few globules of blood, with the usual precautions, for microscopic examination. These were found of the natural form, without corrugated edges, or any other appearance indicative of decomposition. I now proceeded to examine the contents of the gall-bladder, and, in order to save your time, will endeavour to condense the particulars thus:—

1st. After examining the external structure of the gall-bladder and washing it with alcohol, it was opened, and the contents allowed to run into a tube. The fluid was tested with great care, and found to be neutral, thus confirming my uniform experience for the last fifteen years, that the human bile, as well as that of graminivorous animals, taking the ox as a type, is never alkaline in its healthy, normal condition, and that, if either the one or the other be decidedly alkaline, it should be rejected for ultimate analysis, since alkalinity is a sure indication that the natural molecular structure of the bile has already been broken up, and that no uniform results can now be obtained.

2nd. On adding alcohol to the contents of the gall-bladder the mucus was separated. It was relatively large in amount, and corroborated a fact which I have observed, without exception, in the large number of human specimens, and still larger of graminivorous and carnivorous, which I have examined. When the contents of the gall-bladder amount to a large quantity the mucus will be found deficient; whilst, on the other hand, the small contents of the gall-bladder indicate a large quantity of mucus. It is also important, in relation to medical jurisprudence, to observe that very generally, if not always, a full gall-bladder indicates that food has not for many hours been partaken of, while an empty gall-bladder is as generally an indication that the digestive and assimilating organs are in active exercise. In this case the whole contents of the gall-bladder amounted only to 55 minims, the mucus formed a considerable portion, and the stomach was occupied with food.

3rd. The bile was diluted with two ounces of alcohol; notwithstanding which, on making use of five minims, for the application of Pettenkofer's test, the beautiful characteristic colour made its appearance in a most satisfactory manner. Again: of the alcoholic solution, being perfectly neutral, five minims were evaporated down and incinerated, and a drop of water added to the almost imperceptible residuum; on applying test paper a most marked alkaline re-agency was the result, thus proving that this specimen of bile is composed of an organic body, in combination with an inorganic alkaline base. The quantity is, of course, not sufficient for ultimate analysis.—*Medical Times and Gazette.*

Preparation of Ferrum Pulveratum. BY WÖHLER.—Medical experience has shown that metallic iron, in a finely divided state, is more efficient than any of the compounds of this metal which have been used. Formerly mechanically powdered bar iron was employed under the name of *ferrum pulveratum*, until in 1840 Quevenne and Miquelard* proposed to obtain it by reducing the oxide by hydrogen. Iron obtained in this manner perfectly pure, appears to have essential advantages over the ordinary, less soluble and carbonaceous bar-iron powder. It is now generally used in France under the name of *fer reduit.*

The mode of preparation is very easy, and may be conducted by any druggist. The most troublesome part is the preparation of pure oxide of iron, if this is done, by precipitation by ammonia. It is better to adopt the following process, recommended by Faraday, for the preparation of polishing powder:—Pure crystals of sulphate of iron are heated in an iron pan until perfectly dehydrated, the powder mixed with twice or three times its weight of pure dry chloride of sodium, introduced into a clay crucible, and heated to redness until it melts. When the melted mass is cold, it is washed with water, and the oxide of iron remains as a crystalline powder of blackish-red colour.

The oxide of iron thus obtained is reduced by ignition to redness in a current of dry hydrogen, either in a glass tube or gun barrel. The gas is generated from iron and sulphuric acid, and care must be taken that the latter is not arsenical. The gas is dried either by sulphuric acid or chloride of calcium, introduced between the generator and the tube containing the oxide.

As soon as atmospheric air is displaced from the apparatus, the tube is heated to full redness, and the temperature and current of hydrogen maintained so long as the formation of water is observed at the open end of the tube. When this is at an end, the tube is removed from the fire, closed at each end, and when cold the reduced iron transferred to a bottle. Care must be taken to prevent access of air to the reduced iron while hot, as it is highly pyrophoric in this state. The reduced iron thus prepared should not appear black in places, which would show that the reduction was imperfect. It should consist of small grey lamelar crystals, of the same form as the oxide of iron. These crystals are porous pseudomorphs, and may, therefore, be reduced to very fine powder with ease.

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* Mémoire sur l'Action Physiologique et Thérapeutique des Ferrugineux. Par Quevenne, in the *Archives de Physiologie*, sous la direction de Bouchardat. No. 2, October, 1854.

When well prepared, the *ferrum pulveratum* should be a light grey powder without lustre. When pressed with a polished substance, it acquires metallic lustre. When heated, it readily burns. It should be perfectly soluble in dilute sulphuric acid with evolution of hydrogen.—*Annalen der Chemie und Pharmacie*, April, 1855.

Preparation of Pure Carbonate of Potash.—Notwithstanding the advantage there would be in using a mixture of nitrate of potash with bitartrate, for the preparation of pure carbonate, on account of the price of the latter, a prejudice exists against this process, on account of a general statement in chemical works, that cyanide of potassium is formed from the nitrogen of the nitrate.

Engelhardt* has found, however, that cyanide of potassium is not produced in this operation; and he also points out, that if it were present in small amount in the ignited substance, it would be entirely decomposed during the subsequent operation of solution and evaporation to dryness; first, into ammonia and formate of potash; and, lastly, into carbonate of potash.

To render more certain the decomposition of any cyanide, Engelhardt sprinkled the red hot residue of the deflagration with water; and he observed that this treatment produced so large an evolution of ammonia, that it might have been inferred thence that the amount of cyanide was considerable. However, cyanide could not be detected by reagents.

Subsequently Wicke† has confirmed the above statements, and he has found that the evolution of ammonia is owing to the presence, in the deflagrated mass, of cyanide of potash, which he extracted with alcohol and obtained in crystals. This salt is decomposed, when the hot mass is sprinkled with water, into carbonate of potash and ammonia.

This mode of preparing carbonate of potash is therefore wholly unobjectionable. Wicke recommends the use of one part nitrate of potash and two parts bitartrate.—*Pharmaceutical Journal.*

Effects of the Baths of Kreuznach in Diseases of Females.—It has recently become fashionable with English physicians to send ladies affected with uterine and other diseases to the baths of Kreuznach. In many cases, no good can be hoped for; and in many the obstinacy of the disease has been increased by insufficient treatment. To prevent patients from being sent improperly, Dr. Engelmann, a physician resident at Kreuznach, has communicated to the *Monthly Journal of Medicine*, for June, 1855, a paper, of which the following are the leading points.

The efficacy of the Kreuznach baths is mainly to be ascribed to the combination of muriate of lime, bromine, and iodine; and hence it will be more especially manifested in those cases in which hypertrophic enlargement or soluble tumours exist, in which cases the grand object is to induce absorption of the tumour by increasing the activity of the absorbent vessels.

Dr. Engelmann examines the uses of these baths in diseases of the mamma, affections of the ovaria, and affections of the uterus.

1. *Diseases of the Mamma.*—It is only non-malignant tumours that can be dispersed under the use of the Kreuznach waters. At the same time, it must be remembered that it is not *every* kind of malignant tumour which is curable by these waters, but only such as come under the following classes:—

(*a*) *Induration of Particular Glands*, arising from inflammation of the breast during lactation or at the time of weaning, or produced by hyperæmia, by mechanical injury, or by cold or anomalous menstruation.

(*b*) *Glandular Hypertrophy* (pancreatic sarcoma of Abernethy, lobular imperfect hypertrophy of Birkett, mammary glandular tumour of Paget). The success of the bathing course depends rather on the previous duration than on the size of the tumour, being most rapid when the tumour is recent. In cases which have come under Dr. Engelmann's observation, after several years, he has perceived no tendency to a fresh growth.

(*c*) *Ectasia or Distention of the Milk-Vessels* is less frequently met with. In all cases which have come under Dr. Engelmann's observation, the tumours had lasted several years; they were always decreased by the use of the baths, and in some cases totally dispersed.

The tumours which cannot be absorbed by the use of the Kreuznach baths, but which otherwise derive benefit from their employment, are (*a*) sarcoma and cystosarcoma of the breast, and simple cysts and cystoids of the same; and (*b*) scirrhous tumours. In these, the size of the tumour is diminished by *absorption of the hypertrophied cellular tissue*, while the disease itself remains unaffected. In cases of sarcomatous and cystic tumours which were operated on after the use of the baths, Dr. Engelmann saw no cases of relapse in those which subsequently came under his notice; and of the scirrhous tumours, those which were removed when small, and had not grown to the skin, nor produced constitutional affection, did not return. But in all cases where the disease had shown none of the well-known characters of malignancy, it always returned after the operation.

When scirrhus has passed into cancer, the use of the Kreuznach waters is injurious. During their use, indeed, there is an apparent amendment; but, when the treatment has terminated, the development of the cancer is more rapid than before, and even sometimes during the treatment, if the baths are more strong.

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* *Neues Jahrbuch fur Pharmacie*, September, 1854.

† *Annalen der Chemie und Pharmacie*, April, 1855.

II. *Affection of the Ovaria.*—The use of the Kreuznach baths is highly pernicious in ovarian cancer, or where there is great exhaustion and hectic fever. In *cysts* of the ovaria, simple *hydrops ovaria*, and the *cystoids*, *cystosarcomatous concretions*, and *alveolar degeneration* of the ovaria, a moderate use of the baths is not directly injurious, but is still unsuitable. Patients with these diseases are repeatedly sent to Kreuznach; but in none of these cases has Dr. Engelmann perceived any benefit (but, sometimes, on the contrary, injury) from the use of the baths, when dropsy has appeared.

The water treatment was attended with benefit only in *solid ovarian tumours* arising from real hypertrophy or effusion of blood, or fibrous tumours without hydræmia, or more constitutional disturbance than could be accounted for by the pressure of the tumour. In carcinoma, the baths will be even injurious; and no good result can be expected in the cases of sarcomatous cysts, with or without bones and hair.

III. *Affections of the Uterus.*—The affections of the uterus which can be efficaciously treated by the Kreuznach waters are *chronic engorgements and indurations of a benignant character*, generally affecting the os uteri, and more rarely the fundus uteri in the entire organ; and *hypertrophy of the uterus*, produced by constant pressure of fibrous tumours. The latter class has comprised the greatest number of uterine affections successfully treated by the Kreuznach waters. The fibrous tumours appeared in various parts of the uterus from within outwards; submucous fibroids were less frequent; and Dr. Engelmann never met with fibrous tumours on the os uteri. *Idiopathic chronic engorgements* of the uterus, from their tendency to congestion, do not admit the use of such strong baths as fibrous tumours. Cases of *polypus* have been mistaken for mucous fibroids, and sent to Kreuznach. The diagnosis, though important, is sometimes difficult. In some cases, during the course of the baths, the polypus has passed through the os uteri. A polypus cannot be absorbed by any means; and the use of the baths is not only a loss of time, but may produce injurious effects on the constitution. There is no doubt, according to Dr. Engelmann, that fibrous tumours can be absorbed, when not entirely of a cartilaginous structure. The diminution sometimes commences in the fibroid itself, when not too solid; and sometimes in the hypertrophied tissue of the uterus. Sometimes the growth of the tumour is merely arrested, and diminution does not begin till after the lapse of some years, on the patient arriving at the climacteric period of life. Tumours of the fundus uteri, which were diminished by the use of the waters, began towards the end of the course to swell, and became softer: in some patients, where submucous fibroid was presumed to exist, a discharge of serous fluid, accompanied with many flakes, appeared during the course.

In affections of this kind, the addition of mother-lye was in proportion to the development of the disease and the constitution of the patient. In some cases, the baths at last contained, in 400 pints of plain mineral water, 23 pounds of muriate of lime, and more than 11 ounces of chloride of sodium. When the constitution is weakened by accidental complaints, the wished for result must be endeavoured to be attained rather by a prolonged use of the baths than by giving too much strength to them. Exhaustion produced by anæmia, in cases of submucous fibroids, does not necessitate the use of weaker baths. Hæmorrhage will only be promoted when the baths are too strong or too warm; if the temperature is above 92 Fahr., either hæmorrhage will occur while the patient is in the bath, or menstruation will come on sooner, and be more copious.

Instrument for Removal of the Ovum in Abortion.—Dr. Churchill exhibited to the Dublin Obstetrical Society, some time since, an instrument which he thought might be useful for removing the ovum when it protrudes just through the os uteri in cases of abortion, and especially in those cases where an undilatable condition of the vagina forbids the introduction of more than one finger. The instrument consists of a steel rod (electro-plated) passing through an elastic catheter. One end of the steel rod is divided into three prongs, curved at their points, and divaricating, but closed by sliding the catheter towards the end. At the upper end, the catheter is guarded by a silver rim, and at the lower, it is furnished with rings, by which it can be moved up and down with one hand. The instrument, guided by the forefinger, is to be passed up to the protruding ovum, and the catheter being withdrawn so as to allow the points to separate as widely as needed, the ovum is to be carefully caught, and the instrument, again closed, withdrawn. If the ovum be not very much decayed, or very adherent, it will be brought away.

DUBLIN: PUBLISHED BY W. B. KELLY,

8, Grafton-street.

LONDON: S. HIGHLEY, 32, Fleet-street.

EDINBURGH: MACLACHLAN & STEWART.

June 15, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.
SENT FREE BY POST.
Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 11.—Vol. II. JULY 1, 1855. Price 5d.

WHITWORTH AND HARDWICKE HOSPITALS.

Case of Ovarian Dropsy, which proved fatal by Inflammation of the Interior of the Cyst.

BY DR. M'DOWEL,

PHYSICIAN TO THE HOSPITALS.

Case *reported by* Mr. Davies, *Clinical Clerk.*

Amelia Crow, æt. 26, admitted into the Whitworth Hospital, May 29, 1854. Patient had been married eight years, and was the mother of four children. She enjoyed extremely good health up to the time of her last confinement, soon after which symptoms of ovarian dropsy commenced. The abdomen slowly enlarged, but menstruation was regularly performed. She had latterly become emaciated, and for some time, owing to the pressure of the fluid, the uterus had been extruded from the pelvis, and was prolapsed.

On admission the abdomen was enormously enlarged; and her size seemed the more remarkable, as she was a woman of very small stature. The abdomen measured forty-eight inches in circumference, and twenty eight inches from the symphysis pubis to the ensiform cartilage. The depression of the umbilicus was obliterated, and the superficial veins were greatly enlarged. The entire of the abdomen was dull on percussion. The patient's general health was very good; and notwithstanding the great accumulation of fluid in the abdomen, she was still of very active habits. She was very urgent that something should be done for her relief, and accordingly the palliative operation of tapping the cyst was performed midway between the pubis and the umbilicus: *eleven gallons and a half of fluid* were withdrawn, which was of a dark green colour, and of an oily consistence. After the operation she recovered perfectly, and for four months there was no tendency to a recurrence of the disease, owing, as we believed, to the careful employment of pressure on the parietes by graduated compresses and a bandage. However, after this period the abdomen again enlarged, and the fluid re-accumulated so very rapidly that six weeks after the abdomen began to enlarge paracentesis was again required—(this was in January, 1855.) Twenty-four hours afterwards, vomiting set in, with slight tenderness of the abdomen and extreme prostration, approaching to collapse. These symptoms were regarded as depending on the supervention of peritonitis of an asthenic or typhoid type by Dr. Gordon, as well as by Dr. M'Dowel.

Opium and stimulants were prescribed. For three or four days her condition was the most critical, but after that period she seemed to rally, and the vomiting ceased, but irregular rigors, with hectic, were now observed, and she lost flesh rapidly. She died of exhaustion three weeks after the second operation.

Post Mortem Examination.—The peritoneum was free from any traces of inflammation, the alarming symptoms which ensued on the second tapping were the result of *inflammation of the interior of the sac,* not of peritonitis; the cyst was of great size, and contained several gallons of thick pus, it occupied almost the entire of the abdomen; the viscera were all displaced upwards, and at first were entirely concealed from view.

The interior of the sac was lined by vascular masses of lymph; the cyst, inferiorly, sprung from the right ovary; the ovary itself was enlarged to the size of a small melon, and a section of it showed a vast number of loculi, filled with various coloured substances, some red, others yellowish, like the matter of tubercle, whilst other cells contained a glairy semi-transparent material.

The left ovary and the uterus were free from disease; the viscera of the thorax and abdomen were healthy.

Observations.—We learn from this case that after the operation of paracentesis in ovarian dropsy, peritonitis is not the only danger to be apprehended, but that inflammation of the sac may supervene, and produce a fatal result with as much certainty, though not so rapidly.

The similarity of the symptoms produced by inflammation of the sac to those which depend on low typhoid peritonitis, is a point of practical importance. From the fatal results of inflammation of the sac in this case, we learn that the plan of injecting stimulating fluids into the cyst for the purpose of *producing inflammation* of its interior, is not devoid of danger, especially when the cyst is of large size.

The preceding case contrasts remarkably with those in which the operation of tapping an ovarian cyst has been repeatedly performed without the supervention of any untoward symptoms. In the case of a woman named Greene, who was under Mr. Adams's care in the House of Industry some years since, the operation was performed upwards of one hundred and twenty times, and by that surgeon alone, at least eighty times. Instances are recorded by Elliotson, Watson, and others, in which the operation has been performed with impunity even more frequently. In the case now recorded, death resulted from the second operation, which was followed by inflammation of the interior of the sac. Sometimes the first operation proves fatal, as when a *non-adherent* cyst is punctured, and the fluid becoming extravasated, gives rise to fatal peritonitis. Under similar circumstances death may be the result apparently of nervous shock, *without the supervention of any inflammation.*[*]

The advocates of the operation of removing the cyst with the diseased ovarium may deduce an argument in its favour from the case now detailed. For if the mere palliative operation of paracentesis cannot be performed without a certain amount of risk (what the risk is there are no statistics to prove), it may be considered worth while, for the sake of the additional risk, to undergo an operation which promises complete immunity from a return of the disease. I will only add that the most recent statistics of ovariotomy have proved more favourable than was formerly anticipated.

MERCER'S HOSPITAL.

Case of Purpura Hæmorrhagica, cured by Gallic Acid and Turpentine.

Reported by MR. HUGH CROSKERY, *Resident Pupil.*

Gurtha Kane, aged 7 years, was admitted into Mercer's Hospital, under the care of Mr. Tagert, on the 11th May, 1855, with well-marked symptoms of purpura hæmorrhagica. About six months ago the child had a mild attack of the disease, and recovered under the use of turpentine. When admitted on the above date, the whole body was covered with dark purple, interspersed with sky-blue, spots, like bruises; and blood oozed continually from the mucous membrane of the mouth and nares. Mr. Tagert ordered the gums and the inner parts of the cheeks to be brushed with a strong solution of nitrate of silver, and at the same time the following mixture:—

℞. Sulph. acidi dil. ʒi.
Infusi rosarum, ℥vii.
Syrupi, ℥i. M.
Sumat cochleare amplum ter quotidie.

At the same time also, gr. i. of tannic acid, rubbed up with a little sugar, four times in the day, and at bed time the following powder:—

℞. Submuriat. hydrargyri, gr. ij.
Pulv. rhei, gr. iij. M.
Et fiat pulvis.

To have an egg for breakfast, and a chop and vegetables for dinner.

12th and 13th. Little improved. To continue the mixture and tannic acid.

14th. Hæmorrhage from the gums still profuse. To be pencilled with the strong solution of nit. argent. as before. Cont. cætera. To get also in the course of the day the calomel and rhubarb powder as ordered on the 11th.

15th. The bleeding from the gums continues, especially at night. To be pencilled over with the solid nitrate of silver, and to gargle the mouth frequently during the day with the following:—

℞. Aluminis, ʒi.
Aquæ, ℥viij. M.
Et fiat gargarisma.

Diet as before.

16th. The child complains to-day of tensive headache, and the urine is of a dark port wine colour, evidently containing a large quantity of blood. To get an ounce of house medicine every two hours till the bowels are well moved, and then small doses of spirits of turpentine.

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[*] See the important case contributed by Sir Philip Crampton, Pathological Transactions, Dublin, vol. i. p. 321.

Diet as before; all else discontinued.

17th. Urine not so dark-coloured; fæces black, and evidently mixed with decomposed blood. The child complains to-day of a severe pain in the right hypochondrium; vomited the house medicine on the preceding day. To have an aperient enema thrown up immediately, and to get two drops of tincture of opium every second hour in effervescence, until eight drops be taken; also a blister over the right hypochondrium.

18th. The symptoms are greatly aggravated this morning; in consequence of the great pain, the child can scarcely bear the weight of the bed-clothes over the site of the blister, which is occupied by a bloody ecchymosed spot. The child had coffee-ground vomiting on yesterday evening in quantity; the hæmorrhage from the gums and bladder had ceased; the pulse is not so quick as on yesterday; the countenance betrays great anxiety and suffering; the breath has been from the first, and still continues, very fetid; the appetite almost gone; to have the blister dressed with a grain of muriate of morphine, and to get turpentine mixture, as ordered on the 16th, every three hours; to have some chicken broth for dinner, and the yolk of an egg, beat up in warm milk and sugar, frequently during the day; to have also a little oil and warm water thrown up by the rectum, in order to clear out the bowels.

19th and 20th. The child is much better today; there has been no return of the hæmorrhage from the gums, bowels, or bladder.

To have some beef tea, and continue the turpentine.

21st. Improving.

22nd. About ten o'clock this morning the child had considerable hæmorrhage from the mucous membrane of the nose; this was promptly arrested by using the following injection:—

℞. Sulphatis zinci, gr. iv.
Acidi tannici, gr. iv.
Aquæ fontanæ, ℥ij. M.
Et fiat injectio.

And by plugging the anterior nares with lint dipped in the solution.

To have a double dose of the turpentine mixture immediately, and five grains of gallic acid three times in the day.

23rd to 25th. No return of the hæmorrhage; hourly improving.

26th. To get the gallic acid powders twice instead of three times a day.

27th. About three o'clock, A. M., the child had bleeding from the nose, which required the nares to be plugged with dry lint, which, with the administration of one of the gallic acid powders, had the desired effect. When Mr. Tagert saw him at half-past nine, A. M., he ordered him to get a tablespoonful of the turpentine mixture as prescribed on the 16th, four times during the day.

28th to 30th. Visibly improving.

31st. As the child is very anæmic, to improve the quality of the blood, and thus prevent further oozing, Mr. Tagert substituted the use of iron for turpentine. The child was accordingly ordered:—

℞. Ferri Carbonatis sacch. ʒj.
Bi-carbonatis sodæ, gr. xxiv.
Pulv. zingiberis, gr. xij. M.
Et divide in chartulas duodecem.
Sumat unam ter indies.

This, however, had to be discontinued on the 4th June. As the boy had again slight hæmorrage from his nose and gums, he was ordered instead, five grains of gallic acid three times during the day.

5th June. As the boy looks pale and exsanguine, Mr. Jameson, into whose hands he passed on the first of the month, thought it well to try quinine with acid during the day. He ordered him also, at bed-time, carbonatis ferri sacch. gr. x.

6th to 11th June. The boy has improved remarkably under the iron and quinine in conjunction with the acid. He is now cheerful and able to run about, and his usual healthy colour has returned. Dismissed cured.

Cases of Poisoning by Cantharides; Recovery.

By DILLON KELLY, M.R.C.S.I.,

MULLINGAR.

March 2nd, two young respectable farmers, one of whom had a *liaison* with a young peasant girl in his neighbourhood, by whom he had had a child, were summoned to attend as jurors at the assizes. The child being at nurse here, both parents met in town, and dined by appointment at the lodgings of the nurse, a soldier's wife, a woman apparently conversant with every trick made use of on such occasions; and, moreover, an adept in the preparation of love potions, and most dexterous in their administration.

After dinner, about 7 P.M., his friend called for him to get him home, took a couple glasses of port wine with him, and not succeeding, went away; after arranging some business, he went to his hotel, and was in bed by ten o'clock.

About half-past eleven, he was awoke by a most urgent desire to pass water, but after considerable straining and great pain, found that a few teaspoonfuls only came away; this was succeeded by a sense of heat and dryness in the mouth and pharynx, with intense thirst, purging, retching, and almost continuous strangury, till at length fearing he had caught cholera (which was epidemic here some short time before), he sent for me.

At one o'clock, A.M., I found him in a state of intense moral and physical anguish, pulse weak and compressible, countenance partially collapsed but flushed, eyes turned up, thirst incessant, tongue brownish, rough, dry, but not loaded; velum pendulum, and so much of the pharynx as could be seen, dry-looking, dark red, but not swollen; strangury of a most painful description; position on his elbows and knees, with head pressing against the pillow during the paroxysms; urine clear, passed almost guttatim, and interspersed with flocculi of transparent pinkish mucus; abdominal muscles hard and rigid.

Suspecting he had stricture, and had drank too freely during the past evening, and so brought on this attack, I questioned him on the subject, but found that such was not the case.

Not knowing what could have produced such severe and grave symptoms, his health up to that period being always most excellent, and he never having had any such before, I was considerably puzzled both as to its cause and nosology, but inclined to the idea that it must have been an attack of nephritic colic with anomalous symptoms.

The treatment, however, was obvious enough. I at once gave him a grain of acetate of morphia, got him into a tepid hip bath, in which I kept him for an hour, adding occasionally warm water to keep up the temperature, and caused him to drink copiously of weak solution of gum, oatmeal tea, and water, which, however, he seldom retained on his stomach for more than a few minutes.

Whilst in attendance on him, I was sent for to see his friend, who I was informed was also taken very suddenly ill; and leaving him in the bath, proceeded to his friend's quarters. On my way, I succeeded in extracting from the soldier's wife a sufficiency of information, which, although most contradictory, was yet clear enough to convince me that a love potion of some sort, most likely cantharides, had been administered by his *chere amie* in the port wine, intended but for one, yet unfortunately partaken of by both. But I shall proceed with my first case.

The retching continuing incessantly, I gave five drops of prussic acid every hour, on a crumb of white sugar, and applied to the pit of the stomach a fold of lint, wetted with laudanum and chloroform, with oiled silk to prevent evaporation, and allowed him some soda water, which he longed for.

Three A.M. The strangury still continuing incessantly, I administered an enema of starch, with a drachm of laudanum, and again got him into the hip bath, which had before relieved that symptom, as he passes water freely, and comparatively without pain, whilst sitting in it; irritability of stomach less; pulse fuller; tongue assuming a more natural appearance; less thirst and dryness of throat.

Five A.M. The retching has not returned since the last dose of prussic acid, now fully an hour; abdominal hardness and rigidity have disappeared, and he has just passed about a wine glassful of bloody urine without pain; thinks he could sleep.

I therefore gave him another grain of acetate of morphia, and directed that he should be kept perfectly quiet till my next visit, but have plenty of barley water, oatmeal tea, or water.

Eight A.M. Slept for about two hours at intervals, since I last saw him; he is now sitting up in bed, with his knees drawn up; has constant desire to pass water; keeps a vessel under the bed clothes, and passes bloody urine almost every ten minutes, without pain; thirst gone; dryness of throat scarcely complained of; says he feels quite comfortable, and wishes for another hip bath; tongue cleaning and getting moist.

Eleven A.M. Slept quietly since nine o'clock; ate some stirabout with appetite, and then went to sleep again.

Two P.M. Says he feels quite well; passes water rather frequently, which is still bloody, but less so than in the forenoon; wishes to get up and have some tea, first premising that he shall have another bath, and then go home, as he fears his friends may be anxious about him.

I therefore gave him a mixture of liquor potass, acetate of morphia, and camphor julep, to be taken every third or fourth hour, and directed him to have a hip bath night and morning till well.

CASE II.—My second patient was very severely affected; his tongue, which was considerably swollen, presented the appearance of a whitish-looking macerated mass; the mucous membrane, separated from the swollen lips, adhered to them in blistered, parboiled-looking folds; copious salivation, velum pendulum and back of the pharynx dark red, and so swollen that three-fourths of the fluid attempted to be swallowed returned by his nose, the act of vomiting being also accompanied by the same phenomenon; intense and excruciating strangury; he also instinctively getting on his elbows and knees during the paroxysms, and parting with but a teaspoonful or two at a time, which was at that period clear, pale, and mixed with transparent pinkish flocculi; articulation greatly affected; pulse 120, small and thready; countenance reckless and slightly flushed.

Treatment as in the preceding case, with the exception of the bath, which could not be procured, but which I attempted to compensate for by constant fomentation.

Four A.M. The second enema of starch and laudanum completely removed the strangury, and for the past half hour he had no desire whatever to pass water; retching still continues; smell of cantharides not only perceptible in the fluid ejected but also in the room and adjoining lobby.

Ten A.M. Had some disturbed sleep between the paroxysms of vomiting, which no treatment has as yet checked, and which are accompanied very frequently by most excruciating pain in the umbilical and pubic regions; lips not so swollen; passed no water since four A.M., and has no desire; bowels not opened since the commencement of the attack.

I now applied a mustard cataplasm over the region of the stomach, and as the retching was rebellious both to acetate of morphia and prussic acid, I gave 30 drops of chloroform in one ounce of mint water, which settled his stomach for some short time, and as the crampy pain in the umbilical and pubic regions now returned with each attack of retching, I obtained a hip bath for him, which gave him some relief, he sleeping almost the whole of the time he remained in it.

Six P.M. Had two more baths since morning, with relief to the pubic pain, but retching and thirst are unabated; less swelling of soft palate and tonsils, so that he speaks and swallows better; also less soreness of throat; pulse down to 100, and stronger; tongue now assuming a white aphthous appearance.

As he wished much to get home, and as his pulse became stronger, under the reaction which had now, to a certain extent, set in, and as I feared the anticipated depression of next day, I prepared him for the journey, by introducing a suppository of four grains of opium, directed him to have another hip-bath at 9 P.M., and five drops of prussic acid, which agreed best with him, although it did not check the retching, and for drink plenty of water, which he preferred.

4th. Eight A.M. Had a bad night; retching incessant; pain only relieved by the bath, so that he had three during that period; passed no water since 10 P.M. yesterday, and feels no desire, but has great pain over the pubes.

Six P.M. Has been complaining for the past three or four hours of great pain in the region of the kidneys; has passed no water for the past sixty-two hours; pain in the pubic region increased in severity; no fulness in the region of the bladder, so that complete suppression has been the result.

To relieve the inflammatory congestion of the kidneys, producing the suppression, I cupped him over the region of each; gave another enema of starch and laudanum, and ordered another hip-bath, with complete relief to those symptoms, but the retching still continues bad as ever.

5th. Eight A.M. Ejections now bilious, and one-half basonful contained blood, but not in any quantity. Fearing from his drowsiness, and his half-stupid, half-reckless appearance, the accumulation of urea in the blood, I had a drachm of mercurial ointment and ten grains of camphor rubbed over the region of the loins and along the spine; and to establish the peristaltic action and open the bowels, I administered an enema of decoction of alöes and castor oil, which came away after three hours without any addition.

Two P.M. I again threw up another enema of decoction of aloes with four drops of croton oil, and applied counter-irritation to the region of the stomach, and got him into a hip-bath.

Ten P.M. Had a copious natural motion about five, and another at seven o'clock, and passed about a wine-glassful of crimson arterial-looking blood by the urethra, after the last motion, since which the severe pain in the region of the bladder has returned, and is only relieved whilst in the bath. Retching and thirst considerably less.

Directed a hop fomentation in a muslin bag to be applied over the pubic region; and as he fancied hydrocyanic acid relieved him, five drops to be given every three hours.

6th. Nine A.M. Had a good night. The fomentation gave him so much relief that he kept it constantly on, and took no bath; passed about a pint of apparently pure fluid blood without any perceptible trace of urine since last visit; vomiting still present, but not so frequent; ejections loaded with green bile; complains of weakness for the first time.

Acting on the principle laid down by Dr. Osborne, and as nothing had as yet hit in controlling the retching, I tried a quarter grain of nitrate of silver three times a day; and whether the *post hoc* theory is applicable or not in this case I cannot say, but by evening his stomach was settled.

I induced him to take a little cold chicken broth, as he had taken no nourishment since the second; and fearing to carry the mercury too far, I laid it aside, but still continued the camphor.

7th. Passed at least three pints of bloody urine yesterday, which is now assuming a purple appearance, and deposits, when allowed to rest, a large quantity of mucus.

Finding the bloody discharges from the kidneys and bladder weakening him very much, I gave him four grains of gallic acid three times a day, with chicken broth for an ordinary drink; but as yet he has no desire whatever for any solid food; had not a bath since yesterday, but still continues the hop fomentation.

9th. Much improved, as yet no appetite; urine pale, but still loaded with a considerable quantity of blood. Appearance anæmic; conjunctiva pearly; uneasiness in the region of the bladder still complained of, with occasionally most painful twinges darting down the track of the anterior crural nerve. Hop fomentations to be continued, also the gallic acid.

The camphor inunction was discontinued, as it had the effect, in his case, of bringing on a paroxysm of asthma, with which he was occasionally afflicted; the thick mucous expectoration, indicating the disappearance of the attack, was tinged quite black by the gallic acid.

12th. System slightly affected by the mercury; urine paleing progressively, but still bloody; appetite most wretched; takes chicken broth as an ordinary drink, but cannot bear even a particle of solid nourishment.

An alum gargle with tincture of rhatany, and to continue the gallic acid at night.

14th. Had a most disturbed night; appearance haggard, and perfectly anœmic; has tired of broths, and refuses nourishment of every kind; since yesterday complains of the soreness and coldness of his mouth and throat, which, he says, prevent him from swallowing, yet he drinks water freely.

With the exception of slight enlargement of the uvula, and slight redness of the tonsils and pharynx, his throat appeared perfectly normal; teeth covered with yellowish brown, firmly adherent sordes; tongue rather foul; no fetor of breath; urine still depositing red globules in considerable quantity; bowels opened yesterday.

Painted his uvula and pharynx with a strong solution of nitrate of silver, and gave him an egg beaten up with brandy and a morsel of sugar, which he relished very much, and desired it to be repeated three or four times a day, and to have a morphia draught at bed time.

17th. Feels much improved; takes from four to five eggs every day, and now wishes for some soup, but still complains of the coldness and soreness of his mouth preventing him from swallowing anything solid. The saliva, which is at times copious, is excessively cold to his feel; had a motion in the morning, white, as in jaundice.

Five drops of nitro-muriatic acid in water three times a day.

20th. Took some tea and bread yesterday with a relish, and is now sitting up; right elbow the seat of an extremely irritable looking erysipelatous redness surrounding a dark brown sloughy spot, which he made no complaint of before, which must have been the result of pressure and blood poisoning, as he lay constantly on that side; right hip also the seat of a similar affection; urine clear, acid, and slightly albuminous—sp. gr. 1015°. ungt. cetacei et catapl. lini to be applied to elbow and hip; acid drops to be continued.

23rd. Sitting up; eats a little fowl, and with an appetite; still takes a broken up egg three or four times a day; yesterday complained much of a sense of weight and numbness in his back and loins, and passed some high-coloured urine (but without pain), which he says contained a quantity of minute bloody clots, with transparent tail-like appendages; urine to-day slightly albuminous; sleeps well, but still complains of the coldness of his mouth; hip quite well; elbow healing rapidly.

26th. Convalescent, but appearance peculiar, whitish, waxy, parchment-like, with tinge of morbid yellow, yet not emaciated; drives out for the last two days, and feels much improved by the change of air and scene.

He now described for the first time the appearance of imaginary phantoms, which were constantly present during the period of his sub-delirium, which extended over the whole of his illness, from about four hours after he was dosed till the seventeenth day, when he first became conscious that he must have been labouring under considerable sensorial excitement.

They consisted of repulsive and monstrous faces, first appearing at the foot of the bed, and gradually moving upwards till they touched his face, when they would start back to their original position to again perform a similar manœuvre.

The folds of the bed-clothes, too, would at times assume the forms of the most grotesque and hideous, and again of the most beautiful heads, but over them he appeared to exercise the most perfect control, for a blow of his hand at once destroyed the delusion.

This explanation clearly accounted for the frequent use he made of his hands during his illness in smoothing the bed-clothes; yet all through the sub-delirium was so very slight that it was perfectly inappreciable to his attendants, and completely under his control.

Again, his extreme cunning in concealing the cause of his restlessness is another most interesting feature in this case; for he admitted to me that he did not wish any one should perceive it, in fact that he was like a half tipsy man wishing to appear perfectly sober, although he was quite certain he was on the very confines of inebriety.

As those cases have extended over so very long a space, I shall merely call attention to a few prominent points which may be thought worthy of special notice.

First, the exact similarity that existed in the urinary symptoms proper; the same distressing strangury; the same clear urine, with transparent pinkish flocculi passed almost guttatim, and exactly similar physical efforts to obtain relief, marked the commencement of the attacks in both cases.

Again, the rapidity with which the distressing strangury, or the hyper-acute stage, yielded permanently to treatment, about six hours being the greatest period of its duration in either case, the appearance of bloody urine in both marking its cessation, which symptom continued in the first case for eight or nine days, and in the second for nearly three weeks.

In the first case, diarrhœa succeeded the retching almost immediately, and was attended by tormina and tenesmus; in the second the bowels were not opened till the fourth day, and then required most powerful medicines for their solution.

Priapism, a symptom mentioned in every work I have seen as pathognomonic of poisoning by cantharides, was not only absent in both, but even the slightest approach to it was never even felt by either.

Finally, unmistakeable symptoms of blood poisoning and deterioration developed themselves in both cases, as evidenced by the occurrence in the first of successive eruptions of boils in the extremities, partaking of both the characters of anthrax and furuncle; and in the second by those erysipelatous, irritable looking ulcerations which appeared to have been produced by pressure, low vitality, and irritation.

TULLA DISPENSARY AND UNION WORKHOUSE.

Increased Action of Heart and Arteries, with Enlargement of Thyroid Gland.

TO THE EDITOR OF THE DUBLIN HOSPITAL GAZETTE.

Sir,—On reading Dr. Banks' paper in the Hospital Gazette of June 1st, I was struck by the similarity of the symptoms to those of a person who had been a patient of mine some years since, and whose illness, extending over a period of three years, I had a constant opportunity of observing. From notes, taken at the time, I am enabled to give the following particulars of the case:—

The patient (a female, about fifty years of age) sought my advice for a very distressing irritation or itching of the skin without the slightest eruption, when I noticed the strong action of the heart and arteries of the neck, the enlargement of the thyroid gland, and prominence of the eye balls, as described by Dr. Banks in his interesting paper. The pulse was about 120; the ankles were slightly œdematous; the countenance had a peculiarly anxious, haggard expression, and there was extreme emaciation. The action of the arteries was the most violent I ever witnessed, accompanied by a whizzing murmur, and there was also, but not constantly, a soufflet in the cardiac region.

A variety of remedies was tried from time to time, but the following was the plan of treatment from which she derived most benefit: Iron and digitalis combined; extreme quiet, and small quantities of the most nutritious diet given at short intervals. She was directed to use glycerine to allay the cutaneous irritation, and to avoid all exertion, spending the greater part of her time in the recumbent posture. Under this treatment there was a decided, though not a permanent, improvement. The pulse fell to 80, the distress arising from the hurried circulation was relieved, and she improved in appearance, putting up some flesh, but whenever the treatment was discontinued for any length of time there was a return of all bad symptoms. In about twelve months from the time she became a patient of mine, she had a slight attack of jaundice, which yielded readily to treatment, and after this she appeared in pretty fair health for some time; she then left my neighbourhood for some months, and on her return it was quite evident that she was approaching her end; but she lingered on another year, a confirmed invalid, and then died rather suddenly.

I saw the body after death, but was not permitted to make a *post mortem* examination, and therefore I have nothing to point out except the emaciation, and that the thyroid tumour appeared much less than I had supposed it during life.

It is very difficult " to give a local habitation and a name" to this complicated disease. I am convinced it is not a disease of the thyroid body, for I can scarcely conceive it possible that an affection of so unimportant an organ could produce such an impression on the system.

I believe the correct theory to be, that this enlargement of the thyroid gland is a morbid erectile tissue, formed for the purpose of relieving the circulation in this disease in the same way as the spleen is said to act in ague. And this view is, I think, borne out by Dr. Banks' description of the cysts existing in the gland, some of which contained a dark-coloured substance resembling coagulated blood. I know the objection may be urged, why is not enlargement of the thyroid body a constant symptom in diseases characterized by over-action of the heart and arteries? But this appears to be a disease *sui generis*, which may have laws of its own which we do not yet understand.

A case of this description has so many points of interest that, I am sure, I need not apologise for the length of this letter.

Yours truly,

James Molony,

Medical Officer, Tulla Dispensary and Union Workhouse.

Clonmore, Tulla, 14th June, 1855.

Hospital Reports.

RICHMOND SURGICAL HOSPITAL.

There have recently been a large number of important operations performed in this hospital. The following are amongst the most remarkable:—Amputation of the Leg (Hey's flap operation)—Dr. Hutton; Strangulated Inguinal Hernia—Professor Smith; Lithotomy—Dr. Hutton; Femoral Hernia—Dr. Fleming; Removal of Sequestrum in Necrosis (two cases)—Dr. Hutton; Cataract, do; Cancer of the Lip—(two cases)—Dr. Fleming; Removal of Ends of Fragments in un-united Fracture, &c.

We shall briefly notice a few of these cases. The operations for the removal of sequestrum, by Dr. Hutton, are extremely important, as illustrating the great advantages of judicious interference in such cases, a question on which the opinions of surgeons are by no means unanimous.

Case I. was an example of *necrosis of the humerus*, in a boy seventeen years of age. The disease had lasted for twelve months; there were several fistulous openings, the discharge from which was profuse, and the boy's health had, in consequence, suffered much.

The swelling and induration of the soft parts, together with the enlargement of the upper end of the bone, encroached so much on the exterior of the shoulder, as to give the appearance of the joint itself being involved; but as the motions of the articulation were unembarrassed, its integrity was taken for granted.

Operation.—A free incision was made towards the outer portion of the upper part of the arm, passing through the centre of the deltoid muscle, in a direction almost parallel to its fibres: from the centre of this incision a smaller one was carried backwards, so as to produce two small flaps, which were rapidly dissected from the bone. The crown of a small trephine was then applied over one of the cloaca, and a circular opening, as large as a shilling, made into the medullary canal. The sequestrum was now fully exposed, and could be slightly moved in its cavity.

The next step of the operation consisted in dividing the sequestrum into two portions by a pair of small cutting pliers introduced into the opening made by the trephine. The sequestrum was now completely removed in a few minutes; the upper portion came away in detached fragments, but the lower was extracted in one piece, which was about three inches in length. The edges of the wound were then approximated, but not closely brought together, and water dressing applied. There was not much blood lost; no vessel required ligature.

It was formerly objected to this operation, that it was extremely painful and tedious. Chloroform (which, of course, was employed in this case) removes the first objection; and as the operation, now described, was completed in less than fifteen minutes, the second objection is fully answered.

The case has since gone on most favourably. The discharge from the fistulous openings has wholly ceased, and that from the incisions has diminished in proportion with the healing of the wounds. The discharge is now but trifling, and the boy's health is most materially improved.

Case II.—In this case the femur was the bone affected. The patient was 20 years of age, and had laboured under the disease for two years. The swelling engaged the lower half of the thigh, and one fistulous opening existed on the inner side of the limb, four inches above the knee joint. This opening was made the centre of a vertical incision of about three and a-half inches in length, which brought into view a cloaca of sufficient size to admit of the introduction of a large-sized pair of forceps. The trephine was not therefore employed, as in the former case; otherwise, the details of the operation were similar to those already described, and a large sequestrum was, with equal success, extracted from its "living tomb."

This case has also since the operation gone on favourably.

Strangulated Hernia.—Professor Smith. The protrusion was situated in the scrotum and right inguinal region, and according to the patient's account, had occurred suddenly only three hours before his admission. The scrotum was extremely tense, and the inguinal region so exquisitely tender that it was impossible to make a satisfactory examination of the tumour. The vomiting was incessant; the patient's countenance denoted extreme anxiety; he suffered excessive pain, and although the bowels had been well freed by an enema a few hours previously, it was decided in consultation, that as the other symptoms were so very urgent, the operation should not be delayed; it was accordingly performed at 3½ P.M., the patient having been admitted at 11 A.M. The sac was readily and quickly exposed, but some difficulty was experienced in opening it, as owing to excessive tension, it was impossible to pinch it up in the usual manner; a small portion, however, was caught in a forceps, and an opening cautiously made; the necessity of careful manipulation at this stage of the operation was then remarkably illustrated, for as there was not the least trace of fluid in the sac, the intestines were so closely in contact with its inner surface, that they would most certainly have been injured had a less careful mode of procedure been adopted. The sac was then more fully opened, when a large quantity of dark-coloured intestine came into view, coiling the one part over the other, as if endowed with independent vitality. The necessity for operating early was now abundantly manifest. The intestines were extremely congested, and of a dark modena colour. The stricture, which presented a sharp tight edge to the finger, and was situated very high up, (we believe at the internal ring), was divided upwards and outwards, but the knife had to be used more than once before sufficient room was obtained for the return of so large a portion of intestine (certainly not less than 12 inches). Even then much difficulty was experienced in reducing the hernia. Chloroform failed to produce complete anæsthesia, and a portion was no sooner restored to the abdomen than it was again forced out by the contraction of the abdominal parietes; however, by patient manipulation, this difficulty was overcome, and the intestines were replaced uninjured. An unfavourable result was expected from the intense inflammation of the strangulated intestines, and the large amount of serous surface necessarily exposed in the operation.

In the evening, symptoms of peritonitis set in. The most active antiphlogistic treatment was employed, but though for some days the disease was apparently kept in check, yet the case ultimately terminated unsuccessfully, and death ensued on the twelfth day after the operation; vomiting was the predominant symptom throughout. It was impossible to obtain leave to make a *post mortem* examination of the body.

This case presented many remarkable features, as for example, the extreme rapidity with which urgent symptoms became developed, and which is more generally a characteristic of small herniæ than those of large size. We do not think we ever saw a case before in which the symptoms were so urgent as to demand an operation within six hours from the occurrence of strangulation. Another peculiarity in the case was, the absence of any fluid in the hernial sac, a circumstance depending, perhaps, on the short period which had elapsed from the occurrence of strangulation.

Lithotomy.—The subject of this case was a fine little boy, nine years of age. Symptoms of stone had existed for five years. His sufferings were very severe. The first incision was made with a scalpel, the blade of which is short, and its point bevelled and blunted at the back, so as to allow it to run smoothly in the groove of the staff, whilst the handle is longer than that of an ordinary scalpel. With this knife the first incisions were made, and the groove of the staff was laid bare behind the triangular ligament, the membranous portion and the apex of the prostate gland being cut through at this stage of the operation. Dr. Hutton thinks it advisable to open the urethra thus freely, in order to facilitate the entrance of the beaked knife along the groove of the staff into the bladder. When this circumstance has been overlooked, and the urethra too sparingly opened, we have seen great delay in finding the opening in the urethra, and much difficulty consequently experienced in getting the beaked knife passed upon the staff and into the bladder. The staff having been cut upon as before described, the beaked knife (a modification of that recommended by Mr. Blizzard, and which is at present generally used in Dublin)* having been duly lateralized, was passed along the staff into the bladder, and the staff withdrawn, a sufficient opening was then obtained by passing the forefinger of the left hand along the back of the knife into the bladder; the blunt gorget was then introduced along the finger, and on it the forceps. The stone was grasped at once and readily extracted. It was of rather large size, measuring three inches and a quarter in its greatest circumference, and weighing 194 grains. It was extremely rough on the surface, and was composed of oxalate of lime, with a thin coating of triple phosphate. As a small artery continued to bleed, and could not be exposed so as to be ligatured, the "tampon" was introduced, and the wound moderately plugged. The bleeding was thus effectually checked, no untoward symptoms followed, and on the seventh day some urine came by the urethra. The wound is now (three weeks since the operation) almost healed.

Strangulated Femoral Hernia. Mr. Fleming.—The patient was a female, æt. 40. The hernia was of four years' standing, but a truss had never been worn. Symptoms of strangulation had commenced from three to four days previous to admission.

The case seemed to be an unpromising one for the prostration was extreme, and the appearance of the patient was like that of a person labouring under cholera. Chloroform having been administered the *operation* was performed in the usual manner; and the more urgent symptoms of strangulation were promptly relieved, although the bowels were slow in acting afterwards. Rapid recovery ensued.

[This case will appear at more length in a future number.]

Two Cases of *Cancer of the Lip* are also deserving of being mentioned. The patients were brothers, and both of them advanced in years, the one being seventy and the other sixty years of age. In the elder the left half of the lower lip was engaged, and the disease had lasted for six years; in the younger the disease occupied the centre of the lip, and was of nine months' duration. *Neither of them were smokers.* In both cases Mr. Fleming removed the diseased part by the usual V incision, and with very satisfactory results.

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* Vide Sir P. Crampton on Lithotomy, Dublin Quarterly Journal, New Series, No. V., p. 22, where the method of using the knife is delineated.

Dislocation of the Hip.—We had lately an opportunity of seeing an example of dislocation of the femur on the dorsum of the ilium, treated by Professor Smith. All the symptoms of the accident were strongly pronounced. The reduction was effected with the pulleys on the morning of the day after the accident. The apparatus was applied in the usual manner, the patient lying on the uninjured hip; extension was made obliquely downwards and forwards, the direction of the extending force crossing the opposite femur a hand's breadth above the knee. The case is here alluded to, in order to direct attention to the assistance derived from the use of chloroform under such circumstances. Anæsthesia was produced before extension was commenced, as much difficulty was expected in the reduction of the dislocation, the patient being remarkably muscular. However, the extending force had scarcely commenced more than a minute when the muscles began to yield, and in less than two minutes the bone entered its socket without any audible snap, but with a rough grating sensation to the hand.

The perfect use of the limb was very speedily regained.

STEEVENS' HOSPITAL.

[In the present Number we have space for only a portion of the Reports, furnished to us from this Hospital.]

Lithotrity.— —— Mahon, aged 60, applied to Mr. Wilmot for the relief of symptoms indicating stricture of the urethra. An obstruction was discovered in the membranous part of the canal, and appropriate measures were adopted for its removal. In the course of the treatment, however, it soon became manifest that many of the symptoms, particularly the pain, were referrible to something more than simple stricture; accordingly, when the obstruction was sufficiently removed to admit of it, a sound was introduced, and a calculus was discovered, which, on being subsequently measured, proved to be of rather a moderate size. The urine was neutral, and deposited mucus in some abundance.

Lithotrity was had recourse to in this case, and in three sittings the calculus was broken up, and nearly completely expelled; it was found necessary, however, to resort to a fourth, for the reduction of a fragment which was too large to pass through the urethra. At each operation, as a preliminary step, some tepid water (never less than eight ounces in amount) was injected into the bladder; the lithotrite (the one in ordinary use) being then introduced, the stone was seized and crushed about four times in succession. On three of the occasions the patient was placed on Heurteloup's bed, the shoulders being well depressed, with the view of throwing the calculus into the fundus of the bladder; on the fourth the patient was operated on in an ordinary bed, the bolster having been placed beneath the pelvis. Chloroform was never administered, and the patient suffered very little pain at any of the operations. No fragments became impacted in the urethra at any time—the calculus was reduced to unusually small pieces. The composition of the stone was principally the triple phosphate. The most important circumstance, in a practical point of view, connected with this case is, that after the removal of the calculus the chronic inflammation of the lining membrane of the bladder continued; there was still secretion of mucus, and sometimes alkalinity of the urine. There was no appreciable enlargement of the prostate gland, to account for these symptoms.

On two or three occasions the bladder was injected with a few ounces of tepid water acidulated with muriatic acid, which seemed to have a decided influence in diminishing the mucus, and altering the character of the urine. A more beneficial effect, however, was obtained, by the internal administration of the acid largely diluted.

Removal of the Sequestrum in a Case of Necrosis of the Tibia.—J. Ashe, aged thirty-four, a pensioner, was admitted into Steevens' Hospital with necrosis of the left tibia. A number of cloacæ could be detected, particularly at the lower part of the limb, but the dead bone seemed completely fixed. The patient was kept in hospital several weeks with the expectation that the sequestrum might become loose, and thus admit of extraction the more readily. The patient, however, soon became impatient, and urged that something should be done for his relief, to comply with which the first operation was undertaken. A crucial incision was made at about the junction of the middle and lower third of the tibia where the largest cloaca was observable, and the flaps of skin being reflected, a common trephine was applied, and a circular portion of the new case of bone was removed; a strong bone forceps was then employed to enlarge the opening, and with some difficulty four tolerable sized pieces of the sequestrum were extracted. As, however, the sequestrum was constituted of the entire shaft of bone, no further results could be expected from this operation. At the end of three weeks a second operation was resorted to; the trephine was, on this occasion, applied at the upper third of the limb, the new case of bone was cut open with a forceps as freely as possible, without risking too great a diminution in the subsequent solidity of the bone. Owing, however, to the length of the sequestrum, as well as to the absence of any space between it and the new bone, it was found impossible to elevate the former from its bed without the assistance of the chisel and mallet. Accordingly a chisel was applied longitudinally upon the dead bone, by which it was broken into several long splinters; and the whole of it removed except a small portion which lay within the lower part of the bone, and was firmly connected with the lower epiphysis of the tibia. This operation was extremely troublesome, and occupied considerable time.

It is now about a month since the last operation was performed, and the case has gone on very satisfactorily. The interior of the new bone is completely filled up with granulations, and the small piece of sequestrum which remains is rapidly loosening. There is no doubt that in a few days this last portion of dead bone will admit of being extracted through the lower of the two circular openings made by the trephine.

(*To be continued.*)

Reviews.

Professor Roux—*His last Work.*

[We copy from the *Gazette des Hôpitaux* the following observations from the pen of Dr. A. Foucart, on the appearance of the first volume of Roux's posthumous works.]

It is greatly to be deprecated that in our day, on the appearance of any new work by the pen of a youthful practitioner, we are sure to meet with captious minds always ready to exclaim, "In these days every one begins to write too soon, before *experience* can have ripened their judgment. No one should write until long *experience* has enabled them to collect abundance of facts, and to compare them with one another, &c., &c. Moreover, they should wait for full maturity, or even old age, to give to the public the result of their observations." And they instance Morgagni, who did not publish his famous treatise, *De Sedibus et Causis Morborum*, until he was sixty-nine years of age. *Experience!* the great word with which those who have never written would wish to force every one else to follow their example. We are not of this opinion. We are, of course, far from concluding that every one fresh from school should think it necessary to write or publish reflections more or less judicious, and conclusions prematurely drawn from isolated facts, which have been hastily observed. But we think that youth is the time for new thoughts and for bold and original ideas. Newton was but 23 years of age when he made some of his most magnificent discoveries in mathematics. Bichat died at the early age of thirty-one, but what footsteps has he not left in the road of medicine. These were, it is true, men of most extraordinary genius. But how many remarkable works are there which we could enumerate, published within the last fifty years, and which we owe to men who had not yet finished half their career? We will not instance any individual, numbers of them still live, and we would not wish to wound the modesty of any. If by writing when too young we risk publishing some errors, and which we need not be ashamed hereafter to correct, is it not still more true that in writing when too old, we risk never finishing what we have begun? Such has been the case within the last few years with one of the most illustrious representatives of French surgery, Lisfranc, who was unable to finish his *Traité de Médicine Opératoire*, in which he proposed to collect all that he had observed of interest in his long career. Such has been the case, likewise, more recently with a man whose loss we cannot sufficiently lament, we mean Roux, who had seen so much, and whom death has just surprised in the midst of his labours—at the moment even when he had just undertaken an immense work, in which he purposed bequeathing us the fruits of nearly sixty years' study and observation. If he had begun ten years sooner, what would we not have gained which is now lost to us for ever? Roux had, indeed, seen much, and had also retained much—the pupil and friend of Bichat, and later in life of Boyer, to whom he was also very nearly related; rival and colleague of Dupuytren, Richerand, and Marjolin, he had laid up in his capacious memory an unprecedented number of facts, which were always in his recollection, and of which he constantly detailed the minutest points with the greatest accuracy. His brain was a vast storehouse, from whence there issued, with precipitation, too great perhaps, everything which referred directly or indirectly to the subject which at the moment engaged his attention. If he had had more method, Roux would have made an excellent lecturer. Mention any case, and it was seldom but he could adduce another which he had seen ten, fifteen, or thirty years before, and which, in similarity or the reverse, tended clearly to elucidate the diagnosis, prognosis, or treatment. What would have been a good trait in another, was in him a great defect, which the liveliness of his imagination would not let him correct. He often became prolix, and his wonderful command of words was an injury rather than a help to the elucidation of his subject; words usually crowded on his lips; serious facts and jocular tales were alike included in long parentheses, in the middle of which he altogether lost the thread of his original discourse. Add to this a slight stammering in his speech, which he managed to conceal beneath what was really a brilliant profusion of synonymes and epithets, and one will be able to form a nearly correct idea of what kind were the lectures of this successor of Dupuytren—Dupuytren, that model of sober and severe eloquence, with whom Roux formed the most striking contrast.

Roux was an encyclopædia of surgery, whose leaves were turned over with the greatest delight, except in regular formal lectures; but he ought never to have delivered lectures, for what was attractive in his conversation became, when spoken before a class, both irksome to himself and tiresome to his audience. Such was the principal cause why this learned professor was gradually deserted. The class of students seldom attended his lectures. Students require instruction, and they were distracted by those continual digressions from which they could never carry away any meaning; but mere students ought never to have attended his lectures for the purpose of learning surgery; but those who frequented the Hôtel-Dieu, having already finished their education, could seldom go away without having learned something useful and profitable. Roux detailed his failures, and even his mistakes, with a delightful simplicity, and a frankness and candour seldom met with, and thus an admirable lecture very often detailed the results of an unsuccessful case.

As an operator, Roux deservedly enjoyed an unrivalled reputation. He had a quick and perfect hand. It was his great aim to operate quickly and well. He was sometimes blamed for sacrificing to the *citò et jucundè* the *tutò* which, in our opinion, ought to take the lead in the Latin aphorism. It was very questionable, however, whether this reproach was well-founded. Elegance in the practice of surgery is a proof of steadiness of hand, and promptitude of execution is undoubtedly beyond all value to the patient, in whom any awkwardness on the part of the operator is sure to produce additional suffering and agony. Roux's operations were performed with so much skill, that they could not have been better done even if performed more slowly, and if in a very few cases want of success was attributed to this celerity, we would ask, on the other hand, if those who operate slowly have never been unsuccessful?

More than once injustice was done to him during his life; now that he belongs to history, he must be estimated with impartiality, and he is entitled to the strictest justice. He had, of course, like all men, some trivial follies. Who has not smiled at seeing the childish importance that he attached to the application of a blister to the nape of the neck, at the same moment as the operation, in every case in which he was going to extract a cataract, one of his greatest triumphs as a dexterous operator? We talk of follies; has not every one his own? and was not the blister of Roux equalled by the bleeding which Sanson had performed at La Pitié on every patient whose crystalline lens he was about to depress? Roux was not sufficiently a physician, but that was the fault of the time in which he was educated. Surgery and medicine then formed two perfectly distinct branches of the profession, and there was but a single operator of the old school, Lisfranc, whose medical knowledge was at all respectable. At the present day matters are quite altered, and in our brilliant circle of pure surgeons (masters and pupils), there is not one who is not perfectly competent to treat his patient in any emergency after operation, without being obliged to call in one of his colleagues from the medical wards.

It was necessary to take this rapid survey of Roux's talent as a professor, to arrive at his merit as an author. In this latter character, the faults of the lecturer disappear—pen in hand, he no longer finds himself overwhelmed with the multitude of ideas which crowd on him in the lecture-room; he has time to arrange his materials; he becomes clear, correct, and reassumes the superiority acquired by a clear judgment and constant reflection on the numerous cases which pass under his notice. His *Mélanges de Chirurgie et de Physiologie*, his *Voyage à Londres*, and the different memoirs which he published in different periodicals, on staphyloraphy, union by the first intention, aneurisms, show what he was capable of executing when he had the opportunity.

At length, a few years ago, he began to feel (alas! too late) that he had yet duties to perform towards his medical brethren, who had for so long a time surrounded him with so many acts of kindness. He said to himself: "In a profession, where observation is an exhaustible source of new light, and adds incessantly to the sum of our acquired knowledge, each one is accountable to those who come after him for the fruits of his experience. It is a sort of heritage which is due to posterity, and which it has a right to demand." He then steadily set to work, and, under the title of *Quarante Années de Pratique Chirurgicale*, he undertook to recapitulate all that he had seen, observed, collected, and done.

This is the work of which we have the first volume before us, soon to be followed by three other volumes, which will complete it. Fortunately, the manuscript was finished a few months before death struck down this master of French surgery. Part of it was already in type; and the Surgical Society, anxious to preserve this valuable collection, has obtained permission from Roux's family to have it continued under their superintendence. In this work, Roux has adopted one of those unpretending forms, which so well became his talent. He has divided his subject into letters, which he has addressed to different foreign surgeons of eminence of his own day, and of whom he liked to subscribe himself the friend—such as Chelius, Lawrence, Valentin Mott, Riberi. It is not a didactic treatise; it is rather a familiar conversation, in which he details his own notions and reflections on the various improvements which he had devised in operative surgery. Thus, in this first volume, in which he treats of reparative surgery, he describes at length two of the most delicate and important operations with which he has enriched surgery, staphyloraphy and perinæoraphy, operations which alone would have been sufficient to immortalize their author's name. And again, after several interesting general remarks on autoplasty, considered in its widest field, he makes some peculiarly useful and relevant observations on facial autoplasty and hare-lip, the operations for which he considerably modified. In a word, this volume is entirely devoted to the study of everything which belongs to the reparation of deformities. This subject, every one knows, was one which the illustrious professor was particularly fond of, and which he assiduously followed up; and accordingly he has given it the first rank in the series of monographs, which together will form, what we may truly call, his scientific memoirs. We have nothing particular to say on this peculiar subject; what could we say, which is not already known to every one? The extreme importance of it has long since been recognized by all—patients as well as surgeons; let it suffice to repeat here how fortunate we ought to consider ourselves in becoming possessed of this last *débris*—this valuable collection of great literary store, accumulated during so long a series of years, and in being able to place on our shelves—as all his old pupils will do—this living souvenir, in which is revived completely the man whom we thought we had irretrievably lost.

Heller's Pathological Chemistry of the Urine. By Ludvig Dahl, Cand. Med. *Translated from the Norwegian by* William D. Moore, A.B., M.D., T.C.D. 8vo. p. 100. Fannin and Co., Dublin.

This little work is on epitome by Dr. Dahl, of the labours of Dr. Heller, the distinguished pathological chemist of Vienna, which has been translated and illustrated by Dr. Moore. The illustrations consist of several excellent woodcuts, executed by Oldham, and also of several additional paragraphs, which both supply omissions, and by detailing the subsequent researches of continental and our own physicians, considerably enhance the value of Dr. Dahl's work. The author's investigations are not confined to the pathological chemistry of the urine, although that secretion is fully analyzed both in its normal and abnormal conditions; he also devotes a chapter to each of the following subjects: *The Blood in Health and Disease; Milk, its normal and abnormal Composition; Matters discharged by Vomiting; Fæces; and biliary Calculi.* We can truly say, in the words of both the author and translator, that the amount and the kind of information which this little book imparts on each of these subjects is just what is required by the practising physician, to enable him "to avail himself, without disproportionate loss of labour and time, of the assistance afforded by pathological chemistry." The admirably arranged index adds considerably to the value of the work. We can most confidently recommend the work as one of the most useful *manuals* which the practising physician or surgeon can be possessed of.

SELECTIONS FROM BRITISH AND FOREIGN JOURNALS, &c.

Loose Cartilage in the Knee-Joint; Operation of transfixion with Needles unsuccessful. By James Miller, Esq.

This case was brought before the Medico-Chirurgical Society of Edinburgh by Mr. Miller, for the purpose of making "a recantation of a principle of practice which he had inculcated in his text book on Surgery." Mr. Miller's proposed method of treatment was based on the idea, that "the foreign body might be permanently secured in a safe part, by transfixion." It is thus described in his Principles of Surgery:—"The same preparatory treatment (as for Syme's operation) having been employed, and the cartilage having been similarly fixed in a favourable locality, a harelip pin, or finer needle, may be passed through the integuments, so as to entangle the surface of the body in its hold, or should the consistence of this prove not great, it may be more completely transfixed; a few turns of a thread will suffice to keep the needle in its place. After some days, it is gently withdrawn, and rest, with antiphlogistic regimen, is strictly maintained. Sufficient excitement is induced for fibrinous exudation of a plastic kind, along the track of the needle; and thereby the previously moveable substance is fixedly incorporated with the parts, becoming permanently resident, where its presence can produce little or no inconvenience."

The case was as follows:—A young man, æt. 14, was admitted March 7, 1854, with a loose cartilage in his right knee-joint. The symptoms were characteristic, and had existed for six months. After careful preparatory treatment, two harelip needles were inserted over the external condyle, and the body was transfixed, not, however, without great difficulty, from the smoothness of its surface.

March 18. Needles withdrawn, having been inserted for one week; no pain or constitutional disturbance.

March 24. The loose cartilage had slipped from its position, in consequence of incautious handling by a student; it was again transfixed, but with only one needle.

April 14. Needle removed (21 days since the last transfixion); patient got up.

May 2. The cartilage had now been fixed for 18 days, when this morning, on the patient's pulling on his boots, preparatory to his leaving the hospital, it started from its place, and again entered the cavity of the joint.

May 3. Next day Mr. Miller once more transfixed it, but on the 5th violent inflammation set in, resisting the most active and prompt local and general treatment, and after a narrow swim for his life, the poor lad left the hospital with an amputated limb.

This was the first case in which he had put the principle he had advocated to the test of practice. The theory was feasible enough, and for a while, no doubt, all goes well; but to the question, Is the operation a safe one? Is it efficient, even supposing it somewhat dangerous? a decided negative must be given, though, as he had already stated, the needles were again and again introduced and retained with perfect impunity.

Mr. Alexander Wood was of opinion (and in this opinion we warmly concur), that the thanks of the Society should be awarded to Mr. Miller, as a tribute to his candour in bringing this unsuccessful case before their notice. He (Dr. Wood) only wished that the practice of giving unsuccessful as well as successful results, was a little more common, not only among surgeons, but also among physicians. Nothing, he believed, would tend more to the establishment of true principles, and the advancement of their common profession.—*Monthly Journal of Medicine.*

Burn of the Neck, with large Cicatrix; Müller's Plastic Operation. By MR. HANCOCK, *Charing Cross Hospital.*

C. B., æt. 10, admitted under the care of Mr. Hancock, March 3, with extensive cicatrix, involving lower lip, throat, and upper portion of the thorax, the result of a burn incurred four years before.

The deformity was very great; the patient was unable to close her mouth, and the saliva continually escaped; the lower lip and jaw were drawn by a strong band passing from the chin and sides of the jaw, to the sternum and clavicles, completely obliterating the chin, and masking the front of the throat; the front teeth of the lower jaw projected forwards, the jaw itself being twisted by the force of the contraction of the cicatrix, as described by the late Mr. Earle.

Two years previously, the cicatrix had been freely divided, and the flap dissected upwards, until the jaw was freed, but (as is too often the case) the process of contraction recommenced soon after the wound was healed.

On the 17th March, Mr. Hancock performed the operation recommended by Müller.

The patient having been placed on the operating-table, in the semi-reclining position, chloroform was given. An incision was then carried from the sound skin over the trapezius muscle on the right side, transversely across the neck, about an inch above the clavicle, to the trapezius of the opposite side; the skin and fascia were then carefully cut through, down to the sterno-mastoid muscles, exposing their fibres; they were then dissected up until the lower lip and cheeks appeared to be free, but as the neck still continued contracted, Mr. Hancock passed a director behind the sternal attachments of the sterno-mastoid muscles, and divided them on both sides of the neck. This had the desired effect; the mouth could now be closed, and the lower lip approximated to the upper, whilst the skin of the neck was readily adjusted to the under surface of the lower jaw, so as to restore her chin, leaving a wound at the lower part of the neck above eight inches long by five wide.

[The next stage of the operation consisted in procuring a flap from the healthy integuments, to cover this large surface.] By pressing a piece of white paper into the wound, its size and shape were exactly ascertained, and the bloody surface of the paper being then pressed upon the skin covering the left shoulder and deltoid muscle, left the impression of the size of the flap required. This was then dissected up, care being taken to make the flap rather larger than the wound it was designed to fill, but leaving it attached by its upper extremity to the sound skin of the shoulder. The flap thus formed was then turned transversely across the neck, filling up the wound resulting from the division of the cicatrix, and carefully secured by sutures, and supported by compress and bandage, whilst the wound over the shoulder, caused by the removal of the flap, was dressed with water-dressing, and left to granulate.

Notwithstanding the severity of the operation, comparatively little constitutional disturbance ensued. The patient soon acquired the power of closing her mouth at will, and also of drawing up the lower lip over the edge of the teeth, and at this time she is all but well. She has perfect control over her lips; her chin and throat are well developed; and the wound over the shoulder nearly healed.—*Lancet.*

Rupture of the Uterus, without Pelvic Deformity, at the Commencement of Labour; Cæsarian Operation; Death. By H. Hill, M.R.C.S.L., *Ottawa City.*

The following case will be read with painful interest by obstetric practitioners:—

Mrs. K——, æt. 32, of lymphatic temperament, loose fibre, and delicate appearance, but always enjoying good health, was enceinte for the seventh time; hitherto her labours had been perfectly natural, and of ordinary severity (twice she had given birth to twins). On the morning of December 21, at three o'clock, she was suddenly seized with most severe labour pains, and about four o'clock I was at her bedside; on conversing with her, she said at that time she felt but little pain, but that when she disturbed her husband, she had feared the child would have been born before his return from my house, distant about one mile, of such extraordinary severity was the commencement of her labour, but that ever since she has been, comparatively speaking, almost free from any. I sat about half an hour at her bedside, during which time nothing like labour pain was observed, but it struck me as rather extraordinary that she was so much colder than females in her condition usually are. The only explanation I could give of this, unsatisfactory as it appeared, was to attribute it to the weather, which was pretty severe. On arrival of her friend, I went into an adjoining room, so that she could have her bed, &c., properly arranged, where I fell asleep. Probably I was there half an hour before being summoned to the patient; this must have been about 5, A. M.; on questioning her, there was still no appearance of any regular labour pains, but considerable jactitation, and some uneasiness about the front of the belly, which was not hard generally, nor of the size which we should expect with a female, who herself considered she was about to give birth to triplets, as she had jocosely said. I now made a vaginal examination: blood was issuing, but no membranous pouch, lax or distended, could be felt, or any relaxation or dilatation of the os uteri; everything was soft in that direction, except that the head of a child could be felt through the parietes of the uterus at the upper end of the vagina. I must confess I thought it extremely strange. However, in efforts to warm her with hot bricks and bottles, and in persuasive requests to take a little brandy and water occasionally, which, by the way, was repeatedly vomited, perhaps a second half hour elapsed before I made another examination per vaginam. At this time I applied my left hand on the naked abdomen, to see if any auxiliary effort would induce protrusion of the membranes; it failed in doing so, but the attempt sent a chill of horror through my frame, for to the left of the umbilicus I distinctly felt something that appeared like the knuckle of a person's finger, sticking up at right angles to the abdominal parietes. In an instant the horrible truth flashed across me that the uterus had given way at the very first onset of labour, and that the projecting substance was either an elbow or knee of the infant expelled into the cavity of the abdomen. On questioning her as to the existence of this irregularity previous to the accession of labour, and ascertaining that she was sure it never had existed before, I made known to her husband I entertained the greatest alarm for her safety, and requested him to call in Dr. Sewell. On his arrival he confirmed my diagnosis; reaction had come on at this time, some colour appeared in the face, and the pulse was much steadier and firmer than it had been, but still the same absence of any labour pains. Her awful situation was communicated to the husband without any reserve; he insisted that nothing should be left undone to save her, and at his urgent request I reluctantly undertook to remove the fœtus by the cæsarian section. At 8 o'clock was administered eighty drops of laudanum, and at 10 I performed the operation, assisted by Drs. Sewell and Grant. If ever the blessings of chloroform could be fully realized, it would be in the performance of this direful vivisection, which is thereby divested of three-fourths of much that is so dreadful, and from which the hand of the operator shrinks with intensive horror. Never have I witnessed the more perfect action of the anæsthetic; not a sigh or a groan escaped the patient's lips, and when she awoke to the reality after the performance of the operation, which occupied but a short time, emotions of gratitude were among the first indications of returning consciousness. On arriving at the abdominal cavity, through the linea alba, the infant was found with its head and shoulders in the left iliac fossa, with the elbow answering to the angular projection that had too truly pointed out the nature of the case; the placenta was lying in the right iliac fossa, as it was detached from the uterus, and most probably became so at the moment of the birth of the child into the abdomen. It is almost needless to observe the child was dead, although the placental souffle was to be heard on the right side, which fact fully agrees with the opinion recorded by some obstetric writers, that it occasionally exists after the expulsion of the placenta, and consequently leaves the explanation of the "*souffle*" for future obstetric investigation. The child and placenta were removed with as little violence as possible, as also some few clots of blood, the uterus being perfectly contracted; the wound was brought together very nicely by means of the quilled suture, and the patient removed to bed, a wetted cloth applied on the abdomen, and large doses of opium administered at repeated intervals. She was comfortable all day, slept much, and passed a very fair night.

Dec. 22.—Some slight distention of the abdomen, but little pain or uneasiness, some thirst, countenance good, the pulse was becoming rather excited, had passed urine, but no lochial discharge, the opium was continued; at night the countenonce was becoming anxious, more abdominal distention and tenderness, some weeping from the womb, pulse had a jerking character, about 125. She was bled to about 16 oz., and calomel was now added to the opium.

Dec. 23.—Countenance much changed, frequent delirium, bowels very loose, abdominal distention on the increase, but not the pain; at 9 o'clock, P. M., she breathed her last, without the supervention of more acute symptoms than those detailed, having survived the operation fifty-nine hours or thereabouts. A *post mortem examination* took place fourteen hours after death. There was little, if any, attempt at union in the edges of the wound, and also an almost entire absence of inflammation in the peritoneal cavity; the uterus, which was about six inches long by four in breadth, exhibited a frightful chasm on its left side, extending from the fundus nearly into the os; on the opposite side a rupture of structure was observed to a slight extent, exhibiting the commencement of a solution of continuity in that direction also, which was, however, arrested by the violence being expended in the opposite side; the substance of the uterus appeared healthy, but the thinnest part was very visibly that which had given way.—***Montreal Monthly Journal of Medicine.***

On the Prognosis in Effusion of Blood into the Eye. By M. Velpeau.

In a clinical point of view there are three principal forms of hæmatic effusion which call for attention.

I. The blood may be situated in the chambers of the eye occupying the lower portion, if the effusion be not abundant enough to fill all the anterior chamber. We then observe a reddish liquid, having the same disposition as in hypopium, vision being preserved, as a certain number of rays still reach the retina.

II. The membranes of the eye may be the seat of the effusion, which will present varieties accordingly as the blood is situated between the retina and choroid, the choroid and sclerotica, or the sclerotica and conjunctiva. The effusion due to the rupture of the numerous vessels of the choroid may not exhibit any physical symptom when it takes place between the choroid and retina, but the sensibility of the latter membrane is more or less modified. When it occurs between the choroid and sclerotica, the latter assumes a deeper blue than normal. When it is sub-conjunctival, a diffused ecchymosis, like that seen in fracture of the cranium, is observed.

III. When the vitreous humour and the hyaloid membrane are the seat of effusion, immediate loss of vision is the consequence. It is obvious that in these different varieties the prognosis must differ, and must also much depend upon the amount of injury causing or complicating the effusion. Supposing, however, that the eyeball has not been wounded, the importance of the effusion may still depend upon various circumstances.

1. It is less to be feared in young subjects, owing to the active resorbing power their tissues possess. 2. When the effusion takes place into the chambers of the eye, resorption is a very probable event. The effused blood being in constant contact with the aqueous humour becomes, so to say, diluted by it, and may be more readily taken up by the absorbent vessels of the ocular serous membrane. 3. When the effusion takes place between the membranes of the eye, the prognosis is still more favourable, as the numerous vessels upon the surface of and in the tissue of these membranes present the chances of a pretty rapid absorption. 4. Within the vitreous body, on the contrary, absorption takes place with extreme difficulty. A lens depressed into it may remain there during the whole of life, owing to the low vitality of this medium, and the hyaloid membrane, which is almost devoid of vessels. Blood, therefore, effused into the vitreous body, is only very rarely resorbed, even when it exists there in the state of diffuse infiltration. But the importance of such effusion does not cease here, for M. Velpeau is of opinion that unabsorbed hæmatic clots may sometimes become the point of departure of organic diseases of the eye. He has met with several cases in which the patients referred the origin of cancer of the eye to blows received upon the globe. In these cases the vitreous humour was the seat of the hæmophthalmia, and the loss of vision was immediate and persistent. During the first month after the accident absorption may, however, sometimes occur, especially if we employ topical resolvents, together with purgatives and blood-letting, in order to moderate any inflammatory action that may accompany the effusion. But if the month passes without sensible melioration, there is no hope of resorption taking place.—*L' Union Médicale*, No. 45, and ***Medical Times and Gazette.***

DUBLIN: PUBLISHED BY W. B. KELLY,

8, Grafton-street.

LONDON: S. HIGHLEY, 32, Fleet-street.

EDINBURGH: MACLACHLAN & STEWART.

July 1, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.

SENT FREE BY POST.

Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 12.—VOL. II. JULY 15, 1855. PRICE 5D.

CASE OF COMPLETE DISLOCATION OF LOWER JAW.

BY W. COLLES,

SURGEON TO STEEVENS' HOSPITAL.

MISS ——, ætat. 25, living in the neighbourhood of town, in youth had curved spine, but since then enjoyed good health. Applied to me at eight o'clock on the evening of the 23rd ult.; about three hours previously, indulging in a protracted yawn, she felt a jerk in the jaw and found she could not close the mouth. She immediately applied to a medical man in her neighbourhood, who recognized a dislocation, but failed in his efforts at reduction. She then applied to me; the mouth was open, the symphysis of the jaws slightly projecting; on applying the fingers to the angle of the jaw and tracing the ramus upwards, it led in a direction much anterior to the position of the articulating surface. The posterior edge of the bone could be most distinctly felt, and a broad furrow or hollow existed between the bone and the ear. The heads of the bone were felt and perceived prominent in front of their natural position, so that the face appeared broader at this place than natural.

Before attempting reduction, I wished to ascertain the position in which I would have most command of the force to be used. Standing before her I passed both thumbs into the mouth, but felt I would not have a position the most favourable for applying all my force if necessary.

I then stood behind her, and it at once struck me this was the position which afforded most advantages.

Placing her head against my chest, I passed each thumb as far back on the corresponding side of the jaw as possible: by making a rotatory motion from the wrist I found the bone to yield; by now adding a motion of drawing the hand in towards the chest, the left side first, then the right, slipped into their positions, and the patient closed the mouth, the rows of teeth falling into their relative positions, and she now could speak plainly.

I think there are many advantages to be derived from attempting reduction in this posture, viz., the surgeon standing behind the patient, the head applied to his breast, and the thumbs turned inwards on the corresponding angles of the jaw, the fingers under the bone in front.

In the first place, the head is much more secure than in the original process, where it is applied against a wall, because in the latter the surgeon may press down the bone, and the patient generally will draw the head in the same direction by moving the body forward in the chair.

By standing behind the patient, while depressing and pushing back the thumbs, he is pressing forwards with the chest, and thus fixes the head more steadily and assists his manipulations, and even if the patient do move on the chair, a slight motion of his body will suffice to counteract this movement, and retain the head steadily fixed.

Another advantage is, that he can use much more force, because when standing in front he can only use the muscles that depress the hands;

the power of those muscles, and is assisted by the powerful class of muscles that rotate the thumbs inwardly; and, besides, in the former case his pressure is away from his body, whereas in the new position the pressure is more directly downwards and towards himself. The only disadvantage in this proceeding, if it can be considered one, is that the mouth is stretched more than in the original plan.

I know this proceeding may, to many, appear awkward and insufficient; but I would only request the surgeon having such a dislocation to treat, before proceeding to reduction, to do as I did—place himself in both positions, and I have no doubt he will feel convinced that the position in which he can use most force and most advantageously, and also have the motions of the head more under his control, is when he stands behind the patient, and proceeds as above recommended.

Cases of Endocarditis and Pericarditis.

By ROBERT MAYNE, M.B.,

PHYSICIAN TO THE SOUTH DUBLIN UNION WORKHOUSE, AND LECTURER ON PRACTICE OF PHYSIC AT THE CARMICHAEL SCHOOL OF MEDICINE.

It would be difficult to name any class of diseases, in the diagnosis of which auscultation has had more signal success than in the inflammatory diseases of the heart; and, consequently, the experienced physician, now-a-days, seldom fails in such cases to recognize the mischief early, and to treat it vigorously, and, therefore, successfully.

I need scarcely say that we are chiefly indebted to the writings of Dr. Stokes for the satisfactory basis upon which this branch of medicine now rests, and that Watson, Latham, Bouillaud, and others, have likewise contributed largely to our knowledge in this department.

Although, however, much has been done in the diagnosis of cardiac inflammations, yet even still cases of doubt and difficulty occasionally arise in practice, of which some are likely enough to deceive the physician into the belief that there is inflammation where *no* inflammation exists, while others may lead him into the far more dangerous error of overlooking inflammation when it is really present. In this latter category I do not of course mean to include the acute primary endocarditis, or the acute primary pericarditis *of adults*, for it is my conviction that under such conditions these diseases may be recognized with almost unerring precision; but when cardiac inflammations occur in infantile life, or when in the adult they *recur* a second or even a third time, there may be an amount of obscurity about them sufficient to perplex the most experienced.

Thus, when, in an adult, inflammation attacks, whereas standing behind the patient he has for the first time, either the endocardium or the pericardium, it generally induces morbid changes from which highly characteristic physical signs result, and, accordingly, the endocardial murmurs of the one, and the exocardial murmurs of the other, afford proof positive that inflammation is present; but an endocardium which has been inflamed, and has recovered, may again, at some future period, take on inflammatory action, and a pericardium which has been inflamed, and has undergone a cure, may likewise again become inflamed; there will then be a *secondary* endocarditis, or a *secondary* pericarditis to treat, and yet the former of these diseases may be accompanied by *very equivocal* physical signs, and the latter may have no physical signs whatever to reveal its nature.

Pathology offers a ready explanation of these apparent anomalies, for endocarditis, even when it ends favourably, is apt to leave behind it a certain amount of thickening, or of roughness, of the lining membrane of the heart; not sufficient to obstruct the circulation, and, therefore, not productive of any very serious mischief, but, nevertheless, quite sufficient to produce a permanent endocardial murmur. Now, under these circumstances, a secondary endocarditis may arise, and we may then be sorely perplexed to determine whether the murmur belongs to an old inflammation or to a new inflammation, and still more so, to say how much of the murmur may be due to an old inflammation, and how much to a new.

Again, when pericarditis has subsided, it generally leaves the opposite surfaces of the serous membrane glued together by adhesions, more or less numerous in different cases, sufficient, however, in the majority, to prevent any great freedom of motion between the opposite pericardial surfaces; should a secondary pericarditis arise under such circumstances, there may be no attrition murmurs to denote its existence, because without motion there can be no friction, and without friction there can be no friction murmurs.

In *primary* inflammations of the membranes of the heart, then, the physical signs are generally all-sufficient for diagnosis; in *secondary* inflammations, on the contrary, they are frequently insufficient or equivocal. In primary pericarditis or endocarditis general symptoms may be almost discarded, so trustworthy are the physical signs found to be; whereas in secondary inflammations of the very same structures, our chief reliance must be placed upon the *general* indications of cardiac mischief present, so uncertain must the physical signs be considered.

Doctor Latham has put forward these principles forcibly, and they are well illustrated by the following case:—

James Duff first came under my notice upwards of two years ago, being then aged about

13. His disease was rheumatic fever, which pursued its ordinary course, running on for about three weeks with severity, and being but little influenced by the various remedies employed—lemon juice amongst the number.

At one of the frequent stethoscopic examinations which were made during the progress of this boy's disease, well marked endocarditis was discovered. To denote it, there was the characteristic endocardial murmur arising during the progress of acute rheumatism, and there was also a certain amount of cardiac distress, more especially palpitation and dyspnœa.

For this complication active remedies were employed, such as repeated leechings, mercury, and finally blisters; and as frequently happens in such cases, the fever subsided, the palpitations and other cardiac symptoms disappeared, the boy became convalescent, but nevertheless the endocardial murmur persisted. It was a systolic bruit, having its maximum intensity to the left of the sternum, near the sternal extremity of the sixth left rib, and not traceable to any very great distance upwards, along the course of the great arteries connected with the base of the heart.

Upon these grounds it was inferred that the mischief was situated at the mitral valve; but as the pulse was perfectly regular and had fallen in frequency, as there was no evidence of obstruction to the venous circulation, in the way of jugular pulsation or otherwise, and as the boy was able to take exercise without inconvenience, a hope was indulged that the progress of the disease (whatever it had been) was arrested, and he was accordingly discharged from hospital.

By degrees he regained his health and strength, and for a period of more than a year and a half he remained at school without complaining of any illness.

Five months before his death this boy was again brought into one of the Workhouse hospitals, labouring a second time under rheumatic fever. Cardiac symptoms were again present, and, on exploration, the region of the heart now afforded the most unequivocal evidence of pericarditis. Attrition murmurs existed over the heart, and accompanying these, or rather heard through them as it were, I thought I could still distinguish the old endocardial bruit.

The cure was this time unsatisfactory; the system resisted mercurial action, so that it was impossible to induce salivation; however, by local depletion and counter-irritation, &c., the pericarditis was at length subdued, the exocardial murmurs subsided, and the fever slowly declined; but it was evident that the rheumatic inflammation had left the heart in a worse plight than it had found it, because the slightest exertion was sure to produce dyspnœa and palpitation, whilst the valvular murmur still remained with all its former characters.

By careful treatment extending over many weeks, during which repeated blisters, sedatives, and some of the lighter tonics had a fair trial, the boy again recovered sufficiently to take his discharge, and for a considerable length of time subsequently all went on tolerably well; his appetite returned, his sleep was good, and he was able to walk at a moderate pace without any embarrassment to his breathing; but on the 20th of March last, without any assignable cause, he was suddenly seized with symptoms of profound collapse; he fell down in what was considered by the bystanders to be a fainting fit; on recovery from this there was a rigor of unusual severity, followed by intense dyspnœa. At my visit next morning I found him sitting up in bed, his countenance expressive of great distress, and his breathing short and catching. He was unable to lie down, for whenever he attempted to assume the horizontal posture suffocation appeared imminent. There was great congestion of the face, which already exhibited a bloated appearance, the jugular veins stood out prominently at both sides of the neck, and there was tumultuous action of the heart accompanied by a small irregular pulse. In the extremities the circulation was languid, the temperature of the lower limbs being defective. His own sensations led him to refer all his sufferings to the heart, for he pointed to the præcordial region in a very significant manner, although the dyspnœa was so great that it nearly prevented him from speaking.

On exploration of the heart, its action was found tumultuous; the endocardial murmur still was there, accompanied by a certain amount of præcordial dulness, but there were no attrition murmurs; to my ear the endocardial bruit seemed louder than at any previous examination.

My first impressions led me to suspect a fresh attack of cardiac inflammation. It might have been a secondary pericarditis without physical signs, or a secondary endocarditis with the former physical signs intensified. Neither conjecture proved to be the true one; on further examination the sputa were found to be rusty coloured, and an extensive pneumonic crepitus was heard over the back of the right lung. The treatment was now directed to counteract this new complication, but it was all in vain. On the 21st, the entire of the right lung was crepitating; on the 22nd, the crepitus had invaded the lower and posterior portion of the left lung; on the 23rd, he began to rave, and broke out into a profuse cold sweat; on the morning of the 24th he was dead.

At the *post mortem* examination, which took place within twelve hours, the pericardium was found universally adherent to the heart, but the adhesions were easily broken down; there was also considerable vascularity of the opposite surfaces of the serous membrane, but neither recent lymph nor pus to indicate *fresh* inflammation.

At the left side of the heart the endocardium presented unmistakeable signs of *old* inflammation. Both flaps of the mitral valve were thickened and clumsy, they were also roughened by minute granules of organized lymph. The mitral orifice was perceptibly narrowed, but not sufficiently so to have materially diminished the current transmitted through it. It was certain from the appearance presented by the curtains of this valve that some amount of regurgitation had been permitted. There was no evidence whatever of *recent* endocarditis.

The right lung, posteriorly, was solidified; anteriorly, it was engorged from base to apex, presenting the second stage of pneumonia, as described by Stokes, or the first, according to Laennec. The left lung, at its postero-inferior portion, was in precisely the same condition. Death had been produced by the sudden and extensive engorgement of the lungs, no very uncommon consequence of heart disease.

Endocarditis in an Infant four Days old.

Mary Sexton, æt. 20, was delivered of her first child in one of the lying-in wards of the South Dublin Union Workhouse Hospital, after an easy labour, on the 24th of April last. She had been a healthy woman previously. Her infant (a male child) was weakly at birth; its respiration was with difficulty established; from first to last it never attempted to suck, and even its very cry was feeble.

On the fourth day a remarkable change came over this puny infant; it was seized with a screaming fit, after which its surface became cold and blue, symptoms which were speedily followed by quick and laboured breathing.

On seeing this child next morning, I was particularly struck with its aspect, which seemed to indicate some overwhelming thoracic disease. The breathing was very rapid and very short, and yet, the heart's action, when explored by the stethoscope, was found to be remarkably distinct, and even slow, beating exactly ninety in the minute. Notwithstanding this laboured action of the heart, the current of blood transmitted into the arteries was small, for no pulsations could be felt in the radials or other distant branches of the arterial tree. Combined with the quick breathing, the failing pulse, and the laboured action of the heart, there was a singularly loud endocardial murmur. It was a systolic bruit de soufflet, plainly audible over the entire cardiac region, and even beyond it; but it was impossible to determine the exact point at which this murmur was loudest.

In addition to all this, I thought the respiratory murmur over the back of the right lung had a bronchial character (no very easy matter to determine in an infant four days old), perhaps there was an occasional crepitus, of this I was uncertain; but there was little doubt that the corresponding portion of the chest was dull on percussion. From this infant's pinched countenance and exhausted look, it was but too plain that no powers of medicine could be of any avail; but in a diagnostic point of view the case was one of uncommon interest.

Was it a case of congenital malformation of the heart, with consequent congestion and solidification of the lung? This was my first conjecture, and many circumstances appeared to favour it; the original feebleness of the infant, the difficulty with which the circulation was at first established, the coldness and the blueness of the infant's surface, and the loud bruit de soufflet.

Was it a case of endocarditis combined with pneumonia? This solution also occurred to me, and appeared, on the whole, the most probable, in consequence of the lengthened interval between the birth of the child and the development of urgent symptoms; but there were difficulties in the way which made me slow to adopt it. I had never met with endocarditis at such an early age, and the little amount of fever present seemed scarcely to warrant the belief that there could be pneumonia.

All treatment proved utterly useless, the breathing became more and more embarrassed, the surface more and more cold, and more and more blue, until at length a slight convulsive fit, which took place late during the ensuing night, led to a fatal termination.

The *post mortem* examination was made next day in presence of my colleague, Mr. Shannon. The head was not examined. The contents of the abdomen were healthy.

The heart was enormously distended with blood; the left side of the organ, however, preponderated greatly in size over the right; the left ventricle and the left auricle being both filled to the utmost with coagulated blood, resembling in colour and consistence black currant jelly. When this coagulum was removed, *the membrane lining the left ventricle was found to exhibit the most unequivocal marks of inflammation.* At the aortic orifice, the semilunar valves were deep pink in colour, greatly thickened, and glued so firmly and so extensively to each other by their convexities, that the passage from the ventricle into the aorta was reduced to the narrowest dimensions. Lower down the lining membrane of this ventricle was thickened, opaque, and absolutely buff in colour; and by carefully scraping with the edge of a scalpel, firm flakes of false membrane were readily detached from it. The curtains of the mitral valve were thickened, but the left auriculo-ventricular orifice remained widely pervious.

In all the other chambers of the heart, viz. the left auricle, the right ventricle, and the right auricle, the endocardium was healthy, and in its smoothness, its thinness, and its semi-transparency, contrasted very remarkably with the characters which inflammation had stamped upon it, where it lined the left ventricle.

The lungs likewise particularly attracted our attention. The right lung posteriorly, from base to apex, was solid—its colour was of the darkest purple. When incised, its cut surface was dry; anteriorly a vast number of the pulmonary lobules exhibited the very same characters. In the left lung similar changes had taken place, but not by any means so extensively. The upper lobe of the left lung was solid and purple—elsewhere this lung was healthy.

The mucous membrane lining the bronchi and their ramifications was almost black with congestion; but there was no undue amount of secretion in the tubes, nor was the pulmonary tissue particularly friable.

It seemed no very easy matter to determine whether the morbid appearances in the lungs thus detailed, and which have been faithfully delineated by Mr. Connolly, were inflammatory, or simply the result of an obstructed circulation; but to the latter opinion I freely admit that I am a convert.

Many circumstances lead me to conclude that the endocarditis in this case had commenced during uterine life; the great density and opacity of the membrane lining the left ventricle, and the firmness of the adhesions by which the aortic valves mutually cohered, could scarcely have been the result of inflammation of only six and thirty hours' duration; whilst the weakly condition of the infant at birth, and the difficulty with which its circulation was primarily established, would seem to shew that even then there was mischief brewing.

The following appears likely to have been the order in which the morbid changes were developed:—

1st. Inflammation of the lining membrane of the left ventricle of the heart, followed by adhesions between the aortic valves, and gradual obstruction of the aortic orifice.

2nd. Distention of the left ventricle and of the left auricle, the chambers of the heart situated immediately behind the point of obstruction.

3rd. Congestion and solidification of the lungs, organs placed still farther backwards in the course of the circulation.

To some it may appear difficult to believe that life could have been prolonged for even four days, with an aortic orifice so large as a pipe-stopper, and with lungs becoming congested progressively, until not more than one-third of the entire pulmonary structure remained capable of respiration; but, in reply, it may be said, that in very early life infants may exist with an amount of pulmonary disease more than sufficient to kill an adult, because respiration is in them a newly established function, and, therefore, not of such paramount necessity to the system, but that it may be largely encroached upon without immediate extinction of life; and, besides, in the case before us, the pervious ductus arteriosus may have acted as a "diverticulum" from the lungs, permitting the pulmonary congestion to occur very gradually, and, therefore, with comparative impunity.

Dysentery; Hepatic Abscess.

BY J. T. BANKS, M.D.,

PHYSICIAN TO THE WHITWORTH AND HARDWICKE HOSPITALS, AND KING'S PROFESSOR OF PHYSIC.

A boy, aged eleven years, was lately admitted into the Hardwicke Hospital. He presented the aspect of one who had suffered from loss of blood, and was in a state of extreme exhaustion. From the account of his friends it appeared that he had laboured under dysentery for three months, and that the alvine dejections had at times contained a notable amount of blood. From the period of his admission, up to his death, which occurred on the sixth day, diarrhœa was present, which obstinately resisted treatment. On examination of the intestinal canal, the whole extent of the great intestine was found to have undergone profound changes, and about one inch and a-half of the small intestine at its junction with the large.

The mucous membrane was studded with protuberances, some of which were nearly as large as a small pea, and in parts the surface of the elevation was ulcerated. The rectum seemed to have been in the highest degree diseased. There was much submucous infiltration, and the intestines were also dilated. The liver, which was not larger than natural, was found firmly adherent to the diaphragm, and fluctuation could be easily detected. The upper part of the liver was the seat of an abscess of moderate size, the contents of which were pure pus, without any admixture of bile. The walls of the cavity were lined by a membrane. On cutting across the ductus choledocus a considerable quantity of pure pus flowed out.

The frequency of abscess of the liver in intertropical regions and its comparative infrequency in temperate climes, have long been the subject of observation. The connexion of abscess of the liver with dysentery has been especially noted by eastern practitioners. We are informed that in India almost a moiety of the cases of dysentery is complicated with abscess of the liver. The researches of French physicians in Algeria have proved the frequency of hepatic inflammations in the dysentery of that province. Here, the combination is rare; but I have more than once observed it. In the Millbank Penitentiary dysentery prevails frequently; but from Dr. Baly we learn that abscess of the liver has not been found as a complication. In the cases of dysentery observed by Dr. Mayne, in the South Dublin Union, the tissue of the liver was found invariably softened. This was not the case in the present instance; the tissue of the liver, with the exception of the part immediately surrounding the abscess, differed in no respect from healthy hepatic tissue in consistence, but it was unnaturally pale. The age at which this combination of dysentery and abscess of the liver existed is, I apprehend, unusually early. M. Legendre, however, has recorded cases in which hepatitis followed enteritis at a very early period of life.

Cases of Strangulated Femoral Hernia, with Remarks.

BY CHRISTOPHER FLEMING, M.D., M.R.C.S.I.,

SURGEON TO THE RICHMOND HOSPITAL.

Case I.—Mary Bateson, aged 76, a countrywoman, married, and without family, applied at hospital on Wednesday, the 14th June, 1854. She had had hernia in the right groin, which was reducible, and was kept so under the use of a truss. This hernia first appeared about two years back, after a severe straining effort; and it was always manageable until within the last four days, when, from the unequal and unfitting state of the truss, she was obliged to lay it aside, and the hernia became painful and irreducible. She had only applied for medical advice within the last twenty-four hours, and was directed at once to procure admission into hospital.

She reached hospital about 10 o'clock, A.M., and was able to walk into the consulting room, after having travelled a distance of near thirty miles in an ordinary country cart. She was a tall woman, of slender frame, and, for her years, healthy looking; her countenance was placid, and her features not expressive of much pain; her pulse, though quick, was yet steady in its beat, and the surface of the body was warm. She stated that her stomach was now incessantly turning, that she had hiccup, that there was a sense of fulness and of tightness in the abdomen, and that her bowels were obstinately constipated since Sunday—that the lump in the groin was not painful, but that it was hard, and that she failed in her ordinary expedient for reducing it, namely, that of pressing on it with her fingers, when the trunk was fully flexed on the pelvis. On being placed in bed, a tumour, with all the essential characters of femoral hernia, was found in the right groin; it was about the size of an ordinary hen's egg, was irregularly globular, and had tilted over Poupart's ligament. It bore manipulation without much manifestation of pain—was firm, tense, and unyielding, and communicated the sensation of consistence at its neck and body, whilst at its fundus it was slightly tympanitic on palpation, or when filliped with the fingers; there was no discoloration or other abnormal condition of the tegumentary coverings of the tumour; the abdomen was soft and flaccid, was not much distended, and its walls were so very thin and attenuated that the convolutions of the intestines were almost traceable beneath; there was tenderness, but not much, in the vicinity of the hernia, and any position of the limbs or body could be selected without any inconvenience. From the comparatively chronic character of the symptoms of the case, both general and local, and from the non-adoption of any previous treatment, I felt justified in having recourse to ordinary means, with a view to the reduction of the hernia without operation. They were carefully carried into effect: a very copious fæculent evacuation succeeded a cathartic enema, but no substantive improvement could be effected. Towards evening the irritability of the stomach and the hiccup, though somewhat controlled, continued, and the hernial tumour remained stationary. Tobacco fomentations were directed to the abdomen, and two-grain doses of opium (which had been commenced about two o'clock) were ordered to be continued throughout the night; iced drinks were also given.

Thursday, 15th June, 10 o'clock, A.M.—This morning I heard that the woman passed an uneasy night, and that she had little or no sleep, although she had taken six grains of opium. That now she vomited repeatedly; that the hiccup was more constant; that her thirst was urgent; that she had no further discharge from her bowels, and that there was pain and tension in the abdomen. Her countenance was haggard, her pulse quicker, though yet firm, and her skin cool. I found the abdomen more distended, somewhat tender on firm pressure, and also tympanitic. The hernia was much as already noted; it was free from pain, but was very unyielding. Having placed her under the influence of chloroform, and again made an unsuccessful effort at the taxis, I proceeded to the operation by dividing through a portion of integument folded transversely, when the sac of the hernia almost immediately presented itself. Over its neck and body there were considerable congestion and matting together of the superincumbent structure—the fundus was easily isolated. There was no fluid in the sac. At its upper part, a solid mass of ecchymosed omentum was met with, which, when raised from below, exposed a bulging knuckle of intestines, dark, but tense, and shining, and with a healthy, springy feel. There was no effusion on its surface; a tight constriction was found at the inner border of the ring, from under which, when a director was passed, a quantity of straw-coloured fluid escaped. The stricture was very tense, and I divided it with Mr. Trant's knife, which appeared to me of much use in protecting the intestine from injury. I restored the intestine without any trouble, and passing my finger within the ring, found the patch of ecchymosed omentum alluded to matted firmly to the anterior wall of the sac; leaving it there as a sort of truss pad, I dressed the wound in the usual way with the provision of suture, compress, and bandage.

The anæsthetic effects of the chloroform were most satisfactory, and whilst they were yet present, she was removed to her ward. There was some hiccup during the operation, but no vomiting, and the pulse was rather increased in strength than otherwise. All the marked symptoms of strangulation gradually subsided. There was a large and copious fæculent discharge from the bowels within four hours; the stomach became settled, the hiccup subsided, and towards evening there was a perfect restoration of all the important functions. The subsequent progress of the case was interrupted occasionally by those contingencies, general and local, for which every surgeon is prepared, who is conversant with herniotomy, and for the control of which, in the majority of instances, he has efficient resources. Perhaps the most important features to note in the case were symptoms of threatening peritonitis about the fourth day; and again, subsequently, rather obstinate diarrhœa. With respect to the wound, it healed (as the majority of such wounds do) by granulation. About the sixth day from the operation, a most foul sloughing supervened, accompanied with a most fœtid, almost fæculent smelling discharge, and for many days the aspect of the wound was most forbidding. The constitutional symptoms at this period were, moreover, unpromising. The fever present was of a low asthenic character—the pulse was very feeble, often intermittent—the tongue was loaded with a yellowish tenacious fur, but the stomach was steady. Medicine and suitable nutriment were tolerated, and this old lady, before the expiration of three weeks from the date of her admission into hospital, left for home, and, as I learn, now enjoys excellent health.

Case II.—Anne Rooney, aged 50, was brought to hospital about 3 o'clock, A.M., on Monday the 7th May, 1855, with strangulated hernia. She was of medium frame and stature, and mother of thirteen children. For the last five or six years she had a rupture in the left groin, which had suddenly appeared after a violent strain. She could not say whether it ever returned or not, felt no appreciable inconvenience from it, and never wore a truss. On the Saturday previous, after a hard day's work, as a char-woman, the rupture became painful and annoying on making any exertion. Her stomach was irritable; her bowels confined; and vomiting subsequently supervened. She applied at the Netterville Institution; was visited by Mr. Tormey, the resident medical officer; was efficiently treated; and taxis and medicines failing in relieving her, she was sent to hospital. On her admission, the general symptoms of strangulation were present:—The haggard countenance and sunken eye were very remarkable; the pulse was very feeble, and the surface of the body cold; there was occasional vomiting and great thirst. The bowels had been acted upon before she reached the hospital, and again when she was transferred to her ward; the motion, on this occasion, was decidedly fæculent; the abdomen was rather soft and flaccid than otherwise; and if any tenderness was evinced on pressure, it was on the right side and in the hypogastrium. In the vicinity of the hernia there was none appreciable, and the hernia itself was free from pain, neither was there much tension.

The tumour was very prominent and very peculiar in shape and direction, and communicated an indistinct sensation of fluctuation. Passing very slightly downwards, it turned abruptly out, and was more in the direction of Poupart's ligament than above it. Its neck was very short; its body so elongated as to approach the spine of the ileum, and its fundus almost pointed. It was dull on percussion. The integuments moved loosely over it, and were free from any discoloration or thickening. The tumour itself could almost be lifted up out of its bed from without, whilst towards the femoral ring it was fixed and unyielding. Pending a consultation, ice was directed to the tumour, iced drinks were also ordered, and a cathartic enema to be administered with the tube. On reaching the hospital about two hours afterwards, I found the symptoms somewhat stationary:—vomiting occurred only once, and the bowels had discharged largely fæculent matter. The countenance and pulse, however, were equally unpromising, indeed, so much so, as to render questionable any operative interference. When carried to the operation theatre the whole aspect of the case was almost choleraic,—it was extremely unhopeful,—the face had a bluish tinge, the hands and nails also—the faintest pulse could alone be felt; moreover, the woman had vomited immediately beforehand a considerable quantity of a darkish brown fluid, sourish, but not of fæculent odour, which added much to her debility. She had no hiccup. The operation, however, was decided upon, and she was placed under the influence of chloroform. Nothing could be more satisfactory, nothing more placid, than the effects of this agent. As regarded the operation, the most remarkable circumstances were the deep cushion of soft fat which lay over the hernial tumour—its very loose external connexions, the ease with which it was exposed, and as if encelated, and the remarkable appearance it presented. The sac was very thin, very tense, and was indented at different portions, so as to give a most deceptive notion of its contents. The greatest caution was required in opening it, it had such a tight, drum-like feel; no fluid was underneath; no omentum; and the intestine was matted to the sac with recent plastic effusion. The shape of it was very peculiar, resembling somewhat a large capsicum berry, or such conoidal form; its colour was a dark chocolate, and it was fully distended with flatus. The stricture was very close, appeared to be situated high up at the ring, and in the neck of the sac, and when freely divided, permitted the easy return of the intestine. The subsequent passing of the finger into the abdomen communicated a sensation of roughness, as if there was a coating of lymph throughout the whole extent of the sac. The local treatment after the operation was much similar to that adopted in the former case, and the constitution required the exhibition of wine and of ammonia, and the application of suitable external stimulants, to diffuse general heat.

Tuesday, May 8th.—On arriving at hospital this morning I learned that after the operation there was no return of vomiting; that the saline draughts and wine directed remained on the stomach, and that the woman gradually rallied from the extreme state of prostration in which she had been before and after the operation; that she had passed urine in large quantities, but that she had no discharge from the bowels. Her countenance indicated the improvement which had taken place; there was no longer the sunken eye, the livid hue of integument; there was rather a blush, and general fulness of visage. The pulse was now distinct and firm, ranging about 80 to 90. The skin was uniformly warm. There was a general feeling of comfort expressed; no complaint of any abdominal tenderness, and the hernia was lost sight of, with the exception of some uneasiness in the situation of the wound.

In the evening reaction was fully established, and a corresponding change was made in the treatment. The progress of the case to recovery was as rapid as it was favourable. The bowels acted on the second day after the operation; no abdominal complication occurred throughout, and the only circumstance to note respecting the wound was, that it necessarily healed by granulation, some superficial sloughing of the surface having taken place.

Remarks.—To some the report of the above cases may appear unnecessarily minute, to others their record may seem devoid of any interest, whilst not a few may approve of the details given, as tending to prepare the surgeon for some of the difficulties which so often embarrass him in abdominal herniæ. By no other means is this latter object more likely to be accomplished than by a detailed hospital report of cases, regularly noted to their termination. Such report is often the best commentary on the special disease with which it is identified. It is free from theoretical notions, and it is, for obvious reasons, thoroughly reliable. The comparatively late period at which each of the above cases was subjected to operation in the existing form of hernia,—the chronic character of the attendant constitutional and local symptoms,—the presence of fæcal discharge, particularly in the case of Rooney,—the varying intensity of the general symptoms of strangulation, where so wide a difference existed between the ages of the individuals,—the satisfactory effects of the inhalation of chloroform notwithstanding—the anatomical peculiarities of the hernial sacs, and of their contents,—the deceptive impression derived from palpation or from percussion, as regarded the latter,—the extraordinary restorative powers in the unpromising case of Rooney, and the curative processes set up in each, constitute important items for practical reflections, and amongst them not the least interesting are, the administration of chloroform where collapse was so extreme as in the second case noted, and the peculiarity in the shape and in the direction of the hernial sac, as found in the same case.

SKIN DISEASES.

From the French of M. Maurice Chausit.

BY T. K. BARTON, A.B. M.B. T.C.D., &c.

(*Continued from page* 141.)

M. Chausit gives the following definition of *Eczema*, which is, perhaps, the most common of cutaneous eruptions:

"The term eczema, from the Greek *εκζεειν*, *effervescere*, probably used by the Greek physicians to designate every acute eruption accompanied by active inflammation, is now employed to denominate a disease of the skin characterized by small flattened vesicles crowded together, spread over a surface more or less red, irregular in form, sometimes very extensive, which is the seat of a certain degree of itching, accompanied by a serous secretion more or less abundant, forming scabs, and sometimes thick crusts." He considers the disease under its two forms, acute and chronic; subdividing the former into Eczema Simplex, Eczema Rubrum, and Eczema Impetigenodes, which differ only in degree. The fourth degree is that in which the inflammation is most intense, being impetigo itself. But of those generally considered under the head of Eczema, eczema impetigenodes is the most intense, and demands the greatest attention. M. Chausit thus describes it:—

"Eczema Impetigenodes is the most intense form, or rather the last degree of acute eczema; it frequently appears either as a complication or continuation of eczema simplex or rubrum; but it may be developed spontaneously. The local phenomena are the same as those observed in eczema rubrum, only they are of much greater intensity: the swelling, especially, is excessive. The vesicles lose very soon their serous character and transparency, and assume a yellowish or puriform appearance, becoming large and globular; when these burst they are replaced by a new elementary lesion, which is not a vesicle, nor yet a pustule, but participating of the nature of both; a double character, which we find extending to the secondary products of the eruption; for when these vesicular pustules burst, the sero-purulent fluid which escapes concretes, and forms scales thicker and yellower than those of ordinary eczema, but which have not the irregular aspect, the arrangement in stages, and the deep yellow colour of the crusts of impetigo; they partake of the character of both; resembling leaves placed one overlapping another. When detached, which is easily done, a red secreting surface is exposed. The disease is prolonged by successive crops of vesicles, which become transformed in the same manner, until the force of the inflammation has subsided, when the eczema loses its impetigenous character, and the disease terminates in two or three weeks. Eczema impetigenodes has been considered as an eczema complicated with an impetigo; but if we remember, that in this variety the eruption comes out always by the appearance of vesicles, which transform themselves into vesiculo-pustules, we will be inclined to look upon it, not as a mixture of the two affections, but as an incomplete transformation of one into the other, arising from the intensity of the inflammation, which, as it increases, gives rise to new products, thus causing the complex character of the eruption."

M. Chausit describes three distinct forms of chronic eczema, the clear understanding of which is necessary to prevent mistakes in the diagnosis, and to direct a proper line of treatment of this rebellious complaint.

Chronic Eczema.

"When eczema presents itself in a chronic form, it has generally passed through the stages of eczema rubrum or eczema impetigenodes, and it then constitutes a disease often very troublesome, but most important to study under its different forms. It appears under three different aspects.

"*In the first case,* the principal character of the disease is an incessant secretion, sometimes very profuse. Whether it be that the disease consists in an infinite succession of eruptions closely following one another, or in a permanent disorder of the skin, the whole surface is constantly bathed in a serosity so abundant as to compel the patient constantly to change the linen which he wears; the skin looks as it were macerated with the constant moisture. When we lift up the clothes, saturated with this serum constantly exuding, a red, raw surface is exposed to view, soft and spongy, and marked by the clothes which covered it. This serosity is furnished in part by new vesicles, which are continually forming and secreting; but when we examine a patch of this secreting eczema with a magnifying glass, we see distinctly numerous little open mouths, from which ooze drops of a limpid serosity; these are the orifices of the sudoriferous ducts, which are exposed by the process of maceration which the skin has undergone.

"When this eczema has its seat round the articulations, it gives rise to the most painful fissures; even the most gentle movements cause laceration of the diseased surface, with some loss of blood. Sometimes the surface, becoming more inflamed, is bathed with a thicker ichorous secretion, which concreting, forms large scales, thick, yellow, soft, and but slightly adherent, such as accompany eczema impetigenodes.

"Occasionally this form of chronic eczema extends itself over the whole body, and then constitutes a very serious disease; and, in such cases, M. Cazenave has observed a tendency of the disease to pass into pemphigus, a transformation happily rare, as it is always a very unfavourable sign.

"*In the second form* the secretion is very scanty; it seems as if the moment it escaped on the surface of the skin it was transformed into dry, thin, white scales, under which is a red, shining surface. This is what has been called *scaly eczema,* of which there are two distinct modifications; either the skin seems as it were formed of a scaly mass, composed of whitish mealy-looking molecules, which fall with the slightest touch, or it is smooth and dry, without any trace of secretion, a red polished surface, upon which lie whitish ring-like scales, adherent by their centre, which fall off by degrees, without any appearance of secretion. These two forms of chronic eczema are both curious and frequent, especially the last described.

"*In the third form* there is no trace either of serous or epidermic secretion; the skin seems to have lost the power to produce the results of inflammation. This eczema has its seat usually in the legs, where it presents a truly remarkable appearance. We see neither secretion nor scales; the skin smooth, thin, and shining, seems constituted like the tissue of a cicatrix, and looks as if the disease was already cured. However, eczema still exists, although in this equivocal form, and reveals itself by eruptions, rare, but characteristic. Firm, thin, transparent, colourless scales are found over the skin; and upon further examination, a few patches of small vesicles will be discovered about the margin of the affected integument. Chronic eczema is accompanied by an itching, which varies in intensity from the slightest feeling of formication, to the most burning itching, which torments and exasperates the patient. It is increased in some cases by the use of certain kinds of food, such as coffee, spirits, &c., &c., by any strong mental emotion; also by the heat of the fire, the rubbing of the sheets, and even atmospheric variations.

"Chronic eczema is a disease which continues ordinarily for a long time. When it disappears, either under the influence of appropriate treatment or spontaneously, it leaves after it a brownish very persistent stain, which remains for life."

Eczema presents some variations when it affects particular localities: thus, when its seat is the scalp, if of the secreting form, it will be recognized by the moist and matted hair, and when this is separated, by the excoriated surface beneath. When scaly, the copious fall of scales from the dry shining scalp will announce the disease. When it attacks the ear, which is not unfrequent, it sometimes causes such swelling as to obliterate the elevations and depressions of this organ, and even encroach upon the auditory canal, so as to prevent hearing. When this arises from slow inflammation of the chronic disease, it forms a very serious complication, the possible occurrence of which it is well for the physician to bear in mind in the commencement of the disease. Our space not permitting of more than this cursory glance at the particular forms of eczema, to which M. Chausit devotes several pages, we take him up again at the causes of the disease: —

"Eczema is not unfrequently developed under the influence of external causes: thus, amongst labourers, we find it caused by the heat of the sun; topical irritants, also, frequently produce it; frictions with croton oil or alcaline ointments, or any ointment in which the lard has become rancid; and it is very probable that it is an eczema which we find sometimes follow the use of mercurial ointment, and which has been described under the name of mercurial rash. Eczema is also caused by the continued handling of powdered substances, as amongst grocers, refiners of metals, &c. Most frequently, however, eczema is but the sympathetic expression by the skin of some disturbance of the constitution; thus we find it connected with disorders of digestion; it coincides or alternates with diseases accompanied by hypersecretion, with catarrhal affections, or chronic gastro-enteritis; it alternates with rheumatism or neuralgia. The development of eczema is favoured by mental emotions; by certain seasons of the year, chiefly summer; it principally attacks adults; it is never contagious, but seems often the result of constitutional idiosyncrasy, and in this way may be called hereditary."

Passing over M. Chausit's remarks upon diagnosis and prognosis, inasmuch as we maintain that a sure diagnosis in difficult cases is only to be obtained by *clinical* study and experience; and sufficient has been said for the purposes of prognosis; we come to the important subject of treatment.

"In acute eczema, when the patient is young and strong, we should have recourse to blood-letting and low diet, accompanied with the use of the vegetable acids. With regard to topical applications we must be very careful. Poultices, or tepid fomentation may be employed, but only for a short time; for, if continued, they macerate the skin, and favour the moist, spongy, excoriated state of the diseased surface. When the most acute stage is passed, we may have recourse with advantage to alcaline baths and lotions. But we strongly recommend great caution in the employment of any emollient applications. Dry applications are much better, such as powdered starch, or rice meal.

"When chronic eczema is of slight intensity, it will yield to the means already mentioned, to which we may add acidulated drinks, gelatinous and vapour baths, the latter especially useful in the scaly form of the disease. But in chronic eczema it is chiefly necessary to search for the cause, often obscure, which has brought on the disease, and now renders it so rebellious; if we find disorder of the digestive apparatus, we must have recourse to purgatives, carefully repeated; such as Plummer's pill, or the waters of Pullna. We would advise sulphur internally, or the waters of Enghien or Cauterets when the eczema is connected with some catarrhal affection; and in the same cases we administer the hyposulphite of soda. If the disease resists all the ordinary therapeutic resources, then it is evidently influenced by constitutional predisposition, which gives it, as it were, a right of habitation, and renders it impregnable. We must have recourse now to general measures, more or less energetic according to circumstances; to diaphoretics, antimonials, or the hydrochlorate of lime, which M. Cazenave employs thus:—

℞ Hydrochlorate of lime, crystallized, ʒii. to ʒiv.
Distilled water, ℥xvi.

A tablespoonful to be taken two or three times a day, in some bitter infusion. In fine, we must have recourse to arsenical preparations, with the aid of which M. Cazenave has often obtained unhoped-for good results. Topical applications appear more indicated here than in the acute form; but experience proves them useless, at least, unless very weak. M. Cazenave abstains from all ointments of an irritating nature. When the surface is dry and scaly, he advises alcaline baths, vapour baths, or, better still, the steam douche; the baths or douche ought never to be beyond 30° to 32° R., nor be continued longer than ten minutes. When the eczema is secreting very much, M. Cazenave has obtained great benefit from covering the surfaces with fine linen, which were again covered with gummed calico, and in the evening powdering the surface with dry powdered starch. In eczema of the scalp, when dry, it will be useful to rub the head lightly with the following mixture:—

℞ Turbith mineral, ʒi.
Sublimed sulphur, ʒii.
Simple cerate, ℥i.

In fine, whatever treatment we have recourse to to combat chronic eczema, it will be necessary to continue it with great perseverance, a condition essential to success."

Hospital Reports.

STEEVENS' HOSPITAL.

We commence the present report with the further particulars of the case of *Removal of the Sequestrum in a Case of Necrosis of the Tibia*, by Mr. Wilmot. (See page 171).

Thursday, 5th July.—This morning the last portion of the sequestrum was removed. An incision having been made through the skin for a couple of inches in a direction downwards, commencing from the lower of the two circular openings made by the trephine on a previous occasion, and the edges having been dissected up laterally to a small extent, a strong bone-forceps with curved blades was employed, and the new case was slit open sufficiently to admit of the application of the chisel and mallet. The former instrument was made to bear perpendicularly on the sequestrum as before, by which a long narrow splinter was broken off. The concussion exercised by the hammer had the effect of loosening completely the remainder of the dead bone at its point of connexion with the epiphysis, and on its being seized in a strong tooth forceps it yielded to a vigorous pull. This osseous fragment is fully two inches in length, and is composed of nearly the entire circumference of the bone. It is to be observed, that according to the patient's statement only thirteen months have elapsed since the commencement of the disease.

Removal of Tumour of Neck and Face.

Thursday, 28th June.—This morning Mr. Cusack removed an enormous tumour from the left side of the neck and face. The patient was a healthy looking man, although the disease was of eighteen years' growth. The tumour presented a very uneven surface from the existence of large lobes, into the furrows between which the skin was tightly drawn. Occupying the centre was a deep excavation, bordered by an irregular line of elevated granulations resembling those observed in certain forms of cancerous ulceration. Around this the skin was adherent to the tumour to some extent, but was quite moveable over it along the border and sides. The mass yielded for the most part a firm, resisting feel; in a few spots it conveyed a very deceptive pulsation, somewhat between that of elasticity and fluctuation; it was quite moveable at its base, except immediately behind the lobe of the ear, where it seemed to dip deeply in front of the mastoid process.

The operation was commenced by making a semi-elliptical incision along the anterior border of the ulcerated excavation, throughout the longitudinal extent of the tumour, and from the centre of this, a transverse incision was carried towards the front of the neck. The skin, several layers of condensed areolar tissue, and the platysma (the fibres of which were much thickened) were now rapidly reflected, and the tumour was dissected up to about half the extent of its base, in a direction from before backwards. A second semi-elliptical and transverse incision was then made through the skin and other structures on the opposite side of the excavation; and the knife being insinuated beneath the posterior border of the base of the tumour, its dissection was completed principally in a direction from behind forwards. At the spot in front of the mastoid process, where the tumour was adherent, the operator was obliged to cut through a small portion of the diseased structure, which he then strangulated with a ligature possed deeply around it, by means of a curved needle. Notwithstanding the magnitude of the tumour, its removal was effected with remarkable rapidity, and with a very small amount of bleeding. The flaps of skin were afterwards laid down, and their edges approximated by two or three sutures. The case has gone on since most favourably, and the patient will soon be enabled to leave the hospital.

After its removal, the tumour was found to weigh two pounds three quarters. On making a section of it, its structure presented the characters of a fibro-cellular growth, with more than ordinary infiltration of serum; large white bands could be seen traversing the mass in various directions; and in several places were large circular spots of a yellow colour, having somewhat the appearance and consistence of firmly boiled sago.

Removal of the Sequestrum in a Case of Partial Necrosis of Femur.

Case III.—The subject of this case was a healthy man, aged 27, who had laboured under the disease for seven years. The sequestrum was small, and occupied a situation corresponding with the lower third and outer side of the right thigh. There was one large cloaca in the centre into which the top of the little finger could be introduced. The skin, which was adherent to some extent around the cloaca, having been dissected up, the opening in the new case was enlarged by means of a strong bone forceps; the chisel and mallet were then applied, as in the preceding case, and the sequestrum was broken into longitudinal splinters, which were readily extracted from their bed by a polypus forceps. There was no difficulty experienced in this operation, owing to the width of the new case, and the space which accordingly existed between it and the dead bone. The osseous tissue of the case, however, was extremely hard and compact, thus contrasting with the structure of the new bone in the other case, which *was of so much shorter duration.*

Vascular Wart on the Nose; Removal by Excision.

CASE IV.—The following are the brief particulars of this case:—The patient, a man aged 34, a few weeks since fell, while in a state of intoxication, on his face, and cut his nose slightly, exactly in the mesial line. The wound healed rapidly. In a few days the patient observed a small tumour (which he compares to a "bruised spot") to arise on the little cicatrix; it rapidly enlarged, and became red and granular. When he was admitted into the hospital the tumour was not much larger than a pea, and presented an appearance strongly resembling that of a raspberry. At the end of three days the tumour had attained at least four times its previous size, and during that period had bled on several occasions spontaneously and with considerable profuseness. There was no other annoyance experienced from this little tumour. It was determined to remove the disease with the knife, without further delay; accordingly the base of the tumour was enclosed within an elliptical incision, and the portion of skin to which it was attached was rapidly dissected off. Four or five arteries, about the size of the coronary of the lip, spouted freely for a moment, but the bleeding was immediately restrained by the pressure of a small piece of dry sponge, until each was secured with a ligature. Cicatrization took place very slowly, but up to this period, three weeks from the operation, there is no appearance of a return of the disease.

Correspondence.

To the Editor of the Dublin Hospital Gazette.

SIR,—As the use of a freezing mixture previous to operating is attracting some attention at the present time, I beg to offer the report of a case recently under my care.

The patient was a lad aged about nineteen years. Considerable chronic ulceration existed underneath and at the edges of both the great toe nails. A mixture of equal parts of pounded ice and salt was applied. Each operation, including the freezing process, did not occupy five minutes. The nails were dissected out, leaving a small portion of the matrix, as I was in hopes that if the cause of the ulceration merely was removed, the parts would heal, allowing the nails to be re-produced. Such has been the case. Healthy skin now occupies the seat of ulceration, and the growth of new nails is taking place rapidly. A little hæmorrhage took place as the freezing process was discontinued, when the sensibility of the surface was destroyed. No pain was felt; the parts wetted with iced water soon regained their natural condition.

I remain, &c.,

W. B. PEEBLES, M.B.,

Surgeon to Westport Union Hospitals.

Nature of the Crimean Fevers.

[From Mr. Brabazon, one of the medical officers of the civil hospital at Scutari, we have learned the following relative to Crimean fevers]:—

The cases at present in the hospital are almost all medical, principally fever and diarrhœa. The fevers are either primarily remittent or beginning otherwise they merge into this type, or into the intermittent form. What I mean is this, a patient is admitted with ordinary continued fever, occasionally, but not often, maculated; after awhile well marked remissions, followed by shiverings and copious sweatings, and fresh exacerbations of fever, are observed. It is no easy matter in these cases to obtain complete convalescence, as relapses so frequently occur.

In the cases which prove fatal there is early cerebral complication, and they sink rapidly with typhoid symptoms.

Again, we find cases commencing as remittent fever and then passing into typhus. The Crimean fever appears to be more of the remittent type, which is in fact the character of the fever of the surrounding countries, as for example of Asia Minor. Quinine and wine are the remedies chiefly employed.

I have found the cold *douche* to the head very valuable in preventing the accession of head symptoms, when such were impending; depletion is not warranted, even locally. It seems to me that accidental circumstances produce typhus, the ordinary characters of which are then altered by peculiarities of climate. The climate is very relaxing, hence it is, perhaps, that quinine is of such benefit even in the early stages of the disease; of course we carefully watch for gastric irritation, which is very apt to occur. Effervescing draughts, with hydrocyanic acid, are then of great use.

Reviews.

Practical Observations on Mental and Nervous Disorders. By Alfred Beaumont Maddock, M.D. Simpkin, Marshall, &c., London.

Having been requested to express our opinion on the merits of the above work, we cannot avoid recording our extreme disapprobation of this class of books. They are useless to the profession, for whom, indeed, they are not intended, for they never contain anything new; or anything worth reading or remembering, which has not already appeared in the class books of the subject discussed. They do an incalculable amount of injury to the public, for whom they are expressly written, and to whom they are always directly or indirectly addressed. Whether or not they benefit the writer we cannot say, but from the number of them which, from time to time, issue from the press, we suppose that they must, sometimes at least, bear this fruit.

We regret much to be obliged to range under such a classification a book which yet bears within it evidences of having been written by an unusually well educated physician,—but the impress is too plain to be mistaken,—as in other works of the kind we find it stated that "it is probable that the work may fall into the hands of the general as well as the professional reader." And for this general reader's information we are told that *amenorrhœa* means *suppressed menstruation;* and that *hepatic* is synonymous with *liver disease*; and that the success which has followed the author's practice has been equally perfect and satisfactory, whether his patients have been prescribed for in personal interviews, or "having a large family and a sick child it is more convenient for them to remain at home and have the case treated by letter." In looking over the index to this work we find the word "quackery" very prominent, and on reading the author's remarks on the subject we must beg leave to add that, in our opinion, the vaunting of any general specific, which he most strongly reprehends, is not the only kind of quackery.

The author lays no claim to either novelty or depth of research, and, accordingly, we find him adding his experience to the well known axiom, that cerebral affections are "especially connected with the digestive, assimilating, and excretive organs." This would have been a meritorious object if properly and efficiently carried out, but which, in our opinion, the author has failed to do.

SELECTIONS FROM BRITISH AND FOREIGN JOURNALS, &c.

On Strangulation occurring in empty Hernial Sacs. By M. Chassaignac, *Surgeon of the "Hopital Lariboisière.*

[From this interesting memoir in the *Revue Medico-Chirurgicale* we have selected the following extracts]:—

Two varieties of empty hernial sacs are met with; one, when the sac still communicates with the peritoneal cavity, the other, where all communication has been shut off; the latter differs in no respect from an ordinary cyst.

It is an interesting fact, which this memoir fully illustrates, that the sac of a hernia which has been for a long time unoccupied, either by intestine or by omentum, may be the seat of strangulation, and so give rise to all the symptoms of strangulated hernia. The subject is a novel and an interesting one. The following illustrative cases are condensed from the original:—

Case II.—In September, 1849, M. Chassaignac was called upon to operate on a woman 52 years of age, who had for a long time suffered from an irreducible femoral hernia on the left side. Symptoms of strangulation had existed from the previous evening. The patient had for some time worn an ill-fitting and defective truss; her abdomen was hard, tympanitic; pulse small and frequent; face pale and anxious; there was incessant vomiting, and the discharges from the bowels had ceased. The tumour, which was situated in the left groin, was as large as a hen's egg, and extremely tense and tender to the touch.

The operation was, at once, proceeded with. An incision was made parallel to the ligament of Fallopius [Poupart], and, on dividing several layers, the sac was arrived at; it had a small neck, as large as the little finger; no impulse existed in this, the pedicle of the tumour; neither could anything like intestine be felt within. Hence, from the experience of former cases, M. Chassaignac thought it likely that this was an old hernial sac, distended with fluid from the cavity of the peritoneum. To make sure of this, he punctured the sac with a needle; clear serum escaped, and the sac was completely emptied; on opening it up a communication with the peritoneum was detected. The greater part of the sac was then excised. The symptoms of strangulation were in no degree modified by the operation, but persisted, with even increased intensity. The vomiting continued to be stercoraceous, and the patient died on the following night. There was no *autopsia*, but by M. Cassaignac death was supposed to be owing to the supervention of general peritonitis.

CASE III.—In this case, treated by M. Sanson, in the "Hotel Dieu," the symptoms of strangulated hernia occurred in a woman, æt. 50, who had had a hernial tumour for a long time. The operation was performed, and the sac was found to contain *pus*, but neither intestine nor omentum; it communicated above with the peritoneal cavity by a small opening. Immediately after the operation the symptoms disappeared.

When the sac does not communicate with the peritoneal cavity, the symptoms are less severe, and proportionally less dangerous. For example (CASE IV), a young woman, æt. 29, was treated by M. Chassaignac, who had had a tumour with a hernia in the right groin, for fifteen years, and had worn a truss. For eight days she had suffered much from pain in the tumour. On admission, the tumour in the groin was as large as an orange, red, tense, and very tender on pressure; it extended along the line of the inguinal canal. There was no vomiting, and the bowels acted regularly. The tumour was carefully cut down upon, and, on opening the sac, serum first and then thick *pus* escaped; the cavity was then found to be empty, and did not communicate with the abdomen. It was evidently an old hernial sac, which for a long time had been obliterated at its orifice, and had thus ceased to have any communication with the abdomen. The cavity healed by granulation, and in a month the patient was cured.

In another case, published by M. Haubert, the hernial sac contained blood, forming an *hæmatocele*.

The memoir ends with these conclusions:—

Experience has proved that peritoneal diverticula, the sites of former hernial protrusions, are capable of giving rise to the symptoms of strangulated hernia. The symptoms vary as to whether the sac does or does not communicate with the peritoneal cavity. In the former case, the symptoms may be even more urgent than in ordinary strangulated hernia; in the latter, the symptoms are much milder. Even where a communication exists, the tapis may not cause the fluid to leave the sac. Such old hernial sacs may contain either serum, blood, or pus.

In all the cases known to M. Chassaignac, the affection had been met with in females, and a truss had been used.

When the sac is punctured, it collapses so completely as to show that it contains none of the viscera. The finger alone may fail to find the opening into the abdomen; it should be searched for with a probe, or with some smaller instrument.

Excision of the sac is the best mode of treatment for a case of strangulation of an empty hernial sac.

[We copy from the *Gazette des Hôpitaux* the following interesting case of *Aneurism of the Popliteal Artery, cured in five Days, by alternate Pressure on two different Points of the Femoral Artery*, a plan which has been so eminently successful in this city]:—

M. Depaul, of the Hôpital Necker, details the following case:—A man, 34 years of age, of good constitution, about a month before his entrance into hospital, strained his left leg. He felt no pain at the time, but in a few days he found himself unable to walk, on account of a pain in the left popliteal space, which extended down to his foot; shortly after this he discovered a small tumour, the size of a nut, in the same region.

Upon examining him, M. Depaul found the left popliteal space filled up more than the other. At the inferior part was a tumour the size of a small hen egg, round and smooth, which was the seat of pulsation, with expansion sufficiently strong to raise the hand, and synchronous with the pulse; and, upon placing the stethoscope over it, a loud intermitting bruit de soufflet was audible. The pulsations ceased when pressure was made upon the femoral artery in the groin; pressure in the popliteal space could not be borne by the patient for a moment; the skin was neither red nor œdematous, yet it was the seat of extreme pain upon pressure, so as to give rise to the idea that an abscess was forming round the aneurism. The patient suffered constantly from darting pains down the leg, and a sensation of tingling in his foot. A poultice to the tumour, rest, and low diet were ordered, which soon succeeded in reducing the pain in the tumour, and allowing the patient to sleep quietly at night. M. Depaul now, in consultation with his colleagues, determined to employ pressure, by means of an instrument furnished by M. Charrière, junior, resembling Dr. Carte's instrument used in this city, with the important addition of having *two compressors*, one to be fixed upon the femoral artery, immediately below Poupart's ligament, the other to press upon it in the inferior third of Hunter's canal, just before it passes through the opening into the popliteal space; these were to be employed alternately. The first compression was made at 9 o'clock in the morning, by means of the superior compress, so that the pulsations of the tumour did not exceed those of the healthy artery. During the first twenty-four hours it was necessary to change the pressure eight times, care being taken each time that the change was made not to relax one compress until the other commanded the artery. The longest time during which the patient supported the pressure without change, was three hours and forty-five minutes, and the shortest forty-five minutes. The two compresses had an ellipsoid form; the superior had its largest diameter parallel to the axis of the artery, the inferior being applied transversely. The patient managed the compression himself during the night, and was warned when it was necessary to change it by a burning pain at the point where the pad was, and by pains extending down to the tendo Achillis. Upon the 2nd of August the patient had slept during the previous night; the tumour was much less painful, and there were no longer any starting pains. Upon the 3rd, the pressure had been changed nine times since the preceding visit; the patient felt more confident in his treatment; the pressure was made tighter. Upon the 4th the patient slept four hours during the night; his general state was quite satisfactory. The apparatus was removed in order to have the bed made. Upon making an examination of the tumour before the pressure was removed, it was found harder, its pulsations were weaker, and it could be handled without giving the patient any pain. The pressure was applied then with greater force, so as completely to stop all pulsation in the tumour, and was kept up by the patient during the ensuing night, and until the evening of the following day; it was then taken off to allow the patient to sleep. Examination upon the 6th found the tumour small and hard; pulsation just perceptible; no bruit. The pressure was maintained lightly for a few days more. Upon the 9th the apparatus was finally laid aside. The tumour was small, hard, deep, not easily defined; without any pulsation, without any bruit. A pulsation was detected at the side of the aneurism, which, however, upon further examination, was concluded to be a subcutaneous artery, enlarged. In its upper part, the left femoral pulsated rather more feebly than the right. In its lower part, the pulsation could hardly be detected.

Tubercular Leprosy.

At a meeting of the Medico-Chirurgical Society of Edinburgh, Dr. Broadbent, Resident House Surgeon in the Edinburgh Hospital under Professor Syme, exhibited, at the request of that gentleman, a young man from one of the Hebrides, who had suffered for ten years from tubercular leprosy.

Small raised points like pins'-heads, unaccompanied by pain, appeared first beneath the skin on the right thigh, at first single, afterwards confluent; from the right it extended to the left thigh, and thereafter to the arms and back of the legs. Eventually the face became affected, the nose thickened, the palate and fauces studded with tubercles, rendering the throat sore and deglutition painful. The patient had just been treated with some local mineral waters, and thereafter with iodide of iron internally, and the local external application of iodine, under which treatment the existing crops had diminished, but fresh ones appeared.

When admitted into the hospital (Edinburgh) the following appearances were chiefly noted: general emaciation; fronts and lower parts of thigh covered with tubercles, less marked on arms, forearms, and legs; face large and distorted, as if by a number of fatty tumours; the skin exhibiting a dirty, cheesy colour, changing to blue in cold weather; nose flattened and enlarged; palate and fauces studded with tubercles; voice unchanged; pain on deglutition only when hot liquids are swallowed; remarkable absence of hair over the whole body (except on the scalp), almost none on the pubes; sexual desire not absent; urine natural; some nocturnal perspirations; no hereditary taint could be traced, the rest of the family were healthy, their circumstances were good, and their diet nutritious. He had never himself seen the disease in any other person. Mr. Syme prescribed ten drops of Donovan's triple solution three times a day.

Dr. Otto Spiegelberg, at present on a visit to Professor Simpson, had seen several cases of the disease in Vienna. Professor Helva regarded a certain melancholy, or sorrow, as one of the earliest signs of the disease. The same gentleman had found whole villages in Norway and Sweden full of patients labouring under the disease. The Government had found it necessary to separate the infected. The only treatment adopted was, the administration of iron and a nutritious diet. All the patients he (Dr. Spiegelberg) had seen, died eventually from tubercular disease of the lungs.

Professor Simpson had seen the previous day a similar case—the first that had ever come under his notice. The lady was about sixteen years of age, her father and mother were English; she had been born in Jamaica. The lady had passed some portion of her life in a convent in the Himalaya Mountains, but had never seen the disease there. In her case a symptom of leprosy, mentioned by Barnard Gordon, was present—the disappearance of the muscles between the thumb and forefinger. Professor Simpson showed that leprosy was evidently on the increase in several European countries. In Norway, with a population less than Scotland, 2000 were returned as labouring under leprosy. In Canada two hospitals had been opened for their reception. In Palestine leper villages were still to be seen. Dr. Simpson had little doubt of its contagious character in the early stages.

Case of Rectal Tumour in a little Girl.

On the 21st of October, 1854, Professor Santesson exhibited before the Swedish Society of Physicians a tumour which he had removed from the rectum of a girl aged ten years; it had been attached by a long pedicle to the right side of the bowel, about an inch and half from the orifice of the anus. Having dilated the rectum with the speculum he drew forward the tumour, intending to cut it off and then to cauterize the wound. But such profuse arterial bleeding ensued on the first incision, that he was obliged to apply Velpeau's compressing forceps above the wound, and still higher up a ligature, which then also served to remove the tumour. The girl was well in eight days. The tumour consisted of small compartments converging inwards, which under the microscope were seen to be hypertrophied solitary glands, containing an abundance of epithelium. In answer to a question by Dr. Malmsten as to what symptoms the patient had exhibited, Professor Santesson stated that the vicinity of the anus was never dry, but was constantly bathed with moisture emitting a feculent odour. Dr. Berg remarked that he had seen many cases of such tumours in children, which had got well without surgical interference; that in these cases he had observed the symptom mentioned by Professor Santessen, and in addition hæmorrhage and frequent desire to go to stool. Sometimes the tumours had been visible and occasionally they had caused a prolapse of the rectum.—*Journal für Kinderkrankheiten, March and April,* 1855, p. 318.

[An example of the spontaneous cures alluded to by Dr. Berg is given in Vol. XI. of the present Series of the *Dublin Quarterly Journal.*]

External Use of Cod-Liver Oil in Skin Diseases.

The reader may find in the *Medical Times and Gazette* for January 3, 1853, page 23, a short notice of the employment of cod-liver oil in certain forms of skin disease, more especially in Eczema. The remedy was then new in this country, and the trials on which our observations were founded had been made in St. Bartholomew's hospital, by Mr. Paget, to whom it had been recommended by Professor Malmsten, of Stockholm. Since then the oil has, we believe, been extensively used in England, and with much the same favourable results which Mr. Paget obtained from it. We refer to the matter again, in order to allude to a paper, recently published by Professor Malmsten himself in a Berlin Medical Journal, on the various uses of the fish oils, and more especially on their external employment against intractable skin diseases. The practice of the Swedish physician appears to have been most successful; and amongst the cases narrated as having been cured are examples of chronic and impetignoid eczema, impetigo, psoriasis, chronic pityriasis, and prurigo formicans. The plan adopted differs somewhat from what we have seen followed in this country. Instead of using the oil merely as an ordinary liniment, the affected parts are directed to be kept constantly soaked with it. If the whole skin be affected, the patient is made to lie in bed; all his body and bed linen being saturated with the oil. This system is continued until the skin is restored to health, the patient being allowed an alkaline bath once a week, but no other washing or change of clothes being permitted. To most people the disagreeable nature of such a measure will constitute an almost insuperable objection to its use. We must remember, however, that Professor Malmsten assures us that he has cured, by its help, cases of the most obdurate and distressing kind. The treatment does not appear to have required, as a rule, more than about two weeks; and is said to have shown a wonderful influence in restoring flaccidity, clearness, and healthy colour to the diseased integument. The majority of cases of prurigo formicans baffle, we suspect, the skill of all our English Dermatologists; and in these the patients would generally be found willing to accept a cure by any possible method, without regard to its disagreeableness. Although this author incurs a little suspicion from the rather indiscriminate recommendation of his remedy, yet, on the whole, we think he well supports his assertions. Speaking generally of his facts, they appear to us to bear out the conclusions which we expressed in the former report on this subject, and which we will again quote:—"The class of cases for which the oil seems most applicable is that of chronic eczematous eruptions, unattended by acute inflammation or general pyrexia. In abating the troublesome itching, which frequently accompanies this disease, especially in old people, it has manifested powers superior to those of any other application with which we are acquainted."

Nitric Acid and Sulphur as an Escharotic.

Mr. Cock has recently been employing in some cases under his care in Guy's Hospital, as an escharotic, a compound of nitric acid and sulphur. A paste is made by mixing the strongest nitric acid with sublimated sulphur, until of a proper consistence. This paste is applied to the diseased surface, the surrounding parts having been protected by plaster, as when chloride of zinc is used. The mixture does not run about. It appears to give less pain than the nitric acid alone, and acts longer, producing more of eschar. In one case Mr. Cock employed it to remove a prominent mass of granulations in fungous testis, and it succeeded well. A cure, however, did not result, as a subsequent attack of inflammation aggravated the condition. We understood Mr. Cock that the formula had been suggested to him by Sir Benjamin C. Brodie.

DUBLIN: PUBLISHED BY W. B. KELLY,
8, GRAFTON-STREET.
LONDON: S. HIGHLEY, 32, FLEET-STREET.
EDINBURGH: MACLACHLAN & STEWART.
July 15, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.

SENT FREE BY POST.

** Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 13.—Vol. II. AUGUST 1, 1855. Price 5d.

Tumour in Ileo-cœcal Region; Cancer of the Ileum and Cœcum.

BY DR. LEES,

PHYSICIAN TO THE MEATH HOSPITAL, LECTURER ON THE PRACTICE OF PHYSIC.

Reported by Charles James Egan, A.B., T.C.D.

Joseph Moore, aged twenty-five, unmarried, a servant, admitted into the Meath Hospital, May 30, 1855. States that he had always lived temperately, and enjoyed good health, until six months since, when, after exposure to cold, he was attacked by pain in the right side, at lower edge of last rib; this was slightly relieved by the application of leeches. Shortly after this he felt a tumour in the right iliac region, which has gradually increased, and since its first appearance he has become very much emaciated and anæmic. He was admitted to Sir P. Dun's Hospital, where he remained for some time under the care of Dr. Aquila Smith, and came from that to the Meath Hospital. On admission his skin is dirty white, and never moistened by perspiration, the lips have little colour, and the tongue is clean, pale, and anæmic. There is no tenderness of the abdomen, but there is some rigidity of its muscles, particularly of rectus of right side, and the superficial veins of the left side are enlarged. The abdomen is distended, but no fluctuation of any fluid can be felt. There is some enlargement of the liver, which extends about an inch below the last rib. In the right iliac region, above the spinous process of the ilium and external half of Poupart's ligament, there is a tumour about the size of a hen-egg, hard, slightly nodulated, and immoveable; dull on percussion, without any pulsation, and painful on pressure. He at times suffers dull, but never acute pain, from this. The chest is clear on percussion, and the respiratory murmur is natural. The sounds of the heart are clear, distinct, and unaccompanied by any murmur, although slight venous murmur is present in the jugulars. In the recumbent posture the pulse is 90, but is much increased in upright position. He sleeps badly, and generally lies on his back. Appetite good; slight thirst; bowels in general regular; at times he has suffered from slight diarrhœa, but *never from constipation*. He has never suffered from vomiting or sickness of stomach. He complains of a fœtor, which rises with wind from his stomach. This fœtor can also be perceived as emanating from his whole body. There has never been any swelling of his legs or feet. The urine was examined by Mr. Leet, and found to contain an excess of uric acid; it is of high orange colour, and without sediment.

June 2nd.—He had a slight attack of diarrhœa during night; the fæces are very liquid, and of a dark yellow colour. Pulse 120.

℞. Mistura morphiæ muriatis.

June 6th.—The diarrhœa increased, and he gradually sunk and died quietly in a few days. On dissection the liver appeared enlarged and of a pale buff colour. There was no evidence of peritonitis, but the end of the ileum and head of the cæcum appeared firmly attached to the wall of the abdomen, and on separating them, the cavity of the intestine was laid open, the peritoneum and a portion of the transversalis muscle having been removed by ulcerative destruction; the lower end of the ileum appeared distended with a semi-purulent fluid, but no fæcal matter. The parts were removed and given to Mr. Thomas Hayden, who examined them, and furnished me with the subjoined report:—

"The ileum and cœcum were agglutinated for half an inch below their natural point of junction, and behind this, enfolded in the peritoneum, was situated a mass of enlarged mesenteric glands the size of a hen egg, smooth, firm, and lobulated. The mucous surface of the cœcum, caput coli, and of the lower extremity of the ileum was eroded and ragged, and according to the report of Mr. Egan, who made a section of it before it came under my notice, that portion of the intestine contained a large quantity of pus, which appeared to have been isolated without producing obstruction to the transit of fæcal matter. The ileo-colic valve had been entirely destroyed, and the ileo-cæcal ulcerated at its attached margin; on the iliac side of this valve two apertures were found in the intestinal wall, of an oval figure, and about a quarter of an inch in diameter, through which a portion of the lumbar mass of glands projected from the exterior, adhering to their margins and effectually closing them. Under a stream of water the edges of these apertures were seen to be thinned, and to consist only of the basement membrane, as if, upon the one hand, the serous investment had been absorbed by the *inward* pressure of the glandular growth, and on the other, the epithelial lining removed by the *outward* tendency of the accumulated pus.

"The vermiform appendix was entire, and of the natural size. A section of one of the enlarged glands presented a grey colour, and the consistency and semi-transparency of firm jelly. Under the microscope it exhibited, in great abundance, elementary and fat granules, nuclei and nucleated cells of an average diameter of 1–3900th part of an inch; also some pigmentary cells, and a few alveoli, but no fibres. The liver was in an advanced stage of fatty degeneration."

This case presented many points of interest, particularly in regard to diagnosis, both as to the nature, and also as to the seat of the disease; first, as to its nature, the question being as to whether it was of an inflammatory character, or a strumous, or malignant degeneration; the history of the case, as well as the symptoms on admission, were against the idea of mere inflammatory thickening; the absence of any other evidence of struma, and the healthy state of the lungs, were against its being strumous, so that I decided it was cancerous, although his age, being only 25, was against it; but the great hardness of the tumour, its characters, and the peculiar appearance of the patient, confirmed me in the opinion; next, as to its exact seat, having decided against its being inflammatory, I laid aside any idea of pelvic abscess, typhlitis, or perityphlitis, but I felt undecided as to whether the cancer was primarily seated in the os ilium, or in the glands, or in the intestines. The differential diagnosis was of no importance as far as treatment was concerned, so that I merely treated him with palliatives and nutriment. The morbid appearances were interesting, particularly as regards the situation of the disease, for it is well established, that the small intestine, particularly the ileum, is rarely affected with cancer, and they also helped to explain the absence of those symptoms which are laid down in books as indicative of the disease, for, as there existed no mechanical obstruction to the passing of food, there was no vomiting, no constipation—in fact, except for the presence of the tumour, I should not have suspected the existence of cancer in that situation. In conclusion, I may observe, that there are two principal forms in which cancer affects the intestine:—First, and most frequent, is the annular form, which occurs as an annular deposit of cancerous tissue in the submucous cellular layer, and which causes annular stricture of the intestine. "Enterostenosis scirrhosa," the most frequent variety of stricture that results from alterations in the intestinal coats, and which generally proves fatal by ileus; as the calibre of the intestine is gradually reduced to the size of a crow's quill, or even completely obliterated; or, as in this case, the intestine may be secondarily affected by a propagation of the disease from neighbouring parts, from the lymphatic glands of the mesentery, or from those of the lumbar plexus, in which case it is attacked laterally, and only one side may be involved; but the cancerous degeneration generally extends gradually, and in the secondary form may interfere with the passage of the intestine by protrusion of the morbid growth into it, and thus cause death by obstruction; though in some cases this has been obviated for the time by sloughing of the morbid growth, or, as happened in this case, ulcerative perforation may establish communications between the portions of intestine and the parietes of the abdomen, and thus cause an artificial anus, which would probably have occurred in my patient had he lived long enough.

Further Observations on the Spasmodic Tic of New-born Infants.

BY ALFRED H. M'CLINTOCK, M.D., M.R.I.A.,

MASTER OF THE DUBLIN LYING-IN HOSPITAL, ETC.

In the first number of this Journal (February 1st, 1854), I reported two examples of an affection implicating the facial muscles of young children, that some might consider to be paralysis, but which seemed to me of a directly opposite nature. Another opportunity has been afforded of examining the grounds of this opinion, and of testing the accuracy of the conclusion at which I arrived respecting the pathology of the disease. C. D. was confined in the hospital of her third child, a girl, on the 10th of April, 1855. The labour was rather tedious in the first stage, as the membranes of the ovum had ruptured some days before. On the prominence of the *left* parietal bone of the infant's head was a small yellowish slough, about the size of a sixpenny piece, surrounded by a ring of inflammatory redness. On the second day the characters presented by the face, and noted down at the time, were as follows:—In the quiescent state of the features, the child being awake, there was no distortion or appreciable want of symmetry on either side of the face; but as soon as she cried or smiled, immediately the *left* eye was observed to close, though not completely so, and the corner of the nose and angle of the mouth, of *same* side, were strongly drawn upwards. Observed during sleep the lids of both eyes were found equally and similarly closed, and there was no difference whatsoever between the two sides of the face. The child could suck perfectly well. A poultice was applied over the injured part of the scalp, and by the seventh day the inflammation had quite disappeared, and a small slough had come away, leaving the bone denuded to the size of a fourpenny. With the subsidence of the inflammation, the distortion of the face had become less and less remarkable, so that by the eighth day no want of uniformity could be observed on either side of the face during crying, laughing, or the other actions of the muscles of expression. The child this day left the hospital with its mother; it was a very quiet infant, and, excepting the local ailment, seemed in perfect health.

The leading features in this case were precisely the same as in the two already published, and may be thus summed up, viz.:—1. The existence of a small slough, encircled by inflammation, on the scalp covering the *left* parietal bone. The cause of this slough is in itself an interesting question to consider, but out of place in the present communication. 2. In the quiescent state, whether awake or asleep, there was perfect uniformity of the features on each side of the face. During sleep, both eyes were alike shut. 3. When the facial muscles were called into action, as in smiling, laughing, or crying, immediately distortion of the *left* side of the countenance was remarked; and 4. At these times the *left* eye was partially closed, and the *left* ala nasi and *left* angle of the mouth were drawn upwards and backwards. 5. At the same time, the right side of the face did not at all present that blank, expressionless appearance which is so strikingly exhibited in paralysis. 6. In each of these instances, the child retained the power of shutting at will the *right* eye, which would not have been the case, I think, had there existed paralysis of the muscles supplied by the portio dura of this side. 7. In each instance the child retained the full power of sucking. 8. In each instance, the treatment was directed to the injury, and was of a soothing, emollient kind. In proportion, too, as the inflammation around the wound subsided, a corresponding improvement was noticed in the condition of the affected muscles.

Upon carefully considering and weighing all these facts, I feel persuaded that the only way of satisfactorily explaining aud reconciling them, is on the supposition of an exalted degree of excitability in the muscles to which the *left* portio dura is distributed, consequent upon irritation, from a traumatic cause, in some of its peripheral branches. At all events, this affords a more consistent and satisfactory explanation of all the symptoms, than will the supposition of *paralysis* having existed in the *right* side of the face. That a similar affection is seldom, if ever, observed in the adult after injuries of the scalp, is an argument of little weight against the pathological view here put forward. For, there is no comparison between the susceptibility of the nervous system in the adult, and in young infants; and it is, I conceive, to the exquisite sensibility of their nervous organization that we are to refer this and many of the other spasmodic and convulsive diseases incident to the initial period of life. In the above cases it will be observed that no irregular or spasmodic action of the muscles took place, until the stimulus of volition was directed to them; then, their contraction was unusually energetic, far exceeding that of the counterpart muscles on the opposite side. It seems very probable that an increased degree of irritation in the portio dura nerve would have induced *involuntary* spasms of the muscles that it supplied: and it is interesting to note that such a disease, occurring idiopathically, was actually observed by the late Dr. Graves, and received from him the designation of "Bell's Spasms of the Portio dura." (Clinical Lectures, vol. i. p. 571.)

I am disposed to think that some of the cases believed and reported to be examples of paralysis of the portio dura amongst new-born children, were in reality of the same nature as those above described, and not paralysis at all; judging from my own experience, I should certainly say so, as I have now seen three cases of this kind, and never yet has it fallen to my lot to witness (amongst children of this age) a single instance of true facial paralysis.

Case of Pericarditis in which Cerebritis likewise existed, with Remarks.

BY DR. M'DOWEL,
PHYSICIAN TO THE WHITWORTH AND HARDWICKE HOSPITALS.

The occasional occurrence of "head symptoms" in connexion with carditis, more especially with rheumatic carditis, is notorious to every practical physician. Modern pathology claims the merit of having shown that when such a combination exists, the disturbance of the cerebrum is of a functional character, and does not indicate any positive cerebral lesion. This affection has accordingly been characterized by Dr. Todd as "a disease not of congestion or inflammation, but one of excitement without power." Twenty years ago Dr. Watson directed attention to this point of practice in his clinical lectures (*Medical Gazette*, vol. xvi. 1835), and more recently has given this caution—"Whenever, in acute rheumatism, you find your patient flighty and wandering, or more distinctly delirious, examine carefully the condition of the heart." Several explanations have been given why an organ so remote should be thus frequently involved in the progress of carditic inflammation. Thus, it has been supposed to depend upon the disturbance to the circulation in the brain, the result of myocarditis, which, from analogy, is supposed directly to weaken the muscular power of the heart, or on the influence of that spanæmic condition of the blood which is so usually a concomitant of an access of the rheumatic paroxysm; whilst again, the more mysterious operations of reflex nervous influence have been supposed to account satisfactorily for the phenomena in question.

Be this as it may, the fact itself, and the practical inferences which result from it, are now very generally recognized and acted upon. Indeed so many cautions are given by practical writers on the subject, that there is some danger of our not recognizing the exceptional case of actual cerebral inflammation, when it occurs, as it occasionally does, in the progress of carditis. The following case has consequently some value, I imagine, as furnishing an example of cerebral symptoms which occurred in a case of acute cardiac inflammation, and which were the result, not of functional disturbance only, but of acute cerebral inflammation. Such a case is the more important with reference to treatment, for when the cerebral symptoms depend on functional disturbance of the brain, we cannot (as a general rule) too carefully avoid lowering or depletory measures, such remedies having been known to produce these identical symptoms; under such circumstances wine and even opium are generally indicated, whilst the strength of the patient is to be supported by suitable nourishment. A different course of treatment is obviously to be pursued when actual cerebral inflammation exists, as in the case to be now detailed:—

Case.—*Acute Pericarditis; Cerebral Symptoms; Convulsions; Death.*

Reported by Mr. D. Davies, *Clinical Clerk.*

Anne Whiteside, æt. 9, admitted into the Hardwicke Hospital, February 19, 1855. On admission, the patient complained principally of her head, and was continually throwing her hands up to it. She seemed much prostrated, and was unable to walk, or even to stand. The conjunctivæ were much injected, and the eyes discharged muco-purulent matter in some quantity. At times, the child screamed violently, and irregular convulsions distorted the body. Pulse 142; tongue clean; secretions natural.

Head shaved and leeched.

Mercurial purgative; calomel and James's powder at short intervals.

20th. To-day she is nearly insensible, but still throws her arms about, and screams violently.

22nd. A great improvement is observed in some of the symptoms. The patient has become sensible, and answers all questions with perfect intelligence. Pain in the head is not now complained of, and she no longer screams. A severe pain in the cardiac region was complained of; attention was directed to the heart, and on examination, a very distinct "frottement" was detected; the heart's action was very rapid and tumultuous. The head was observed to be somewhat retracted, whilst the sterno-mastoids and muscles of the nape were rigid, so that the patient was unable to bend her head forwards.

Blister over the heart.
Mercury to be continued.

23rd. Symptoms as on yesterday.

24th. Patient raved a good deal last night; pulse less rapid, but very weak. The "frottement" has disappeared, but there is abnormal dulness over the heart. Pain has ceased to be complained of over the heart, but is now once more referred to the head; pain is also complained of in the right arm, and there seems to be some inability to use it. Patient is now fully under the influence of mercury.

26th. Still complains of pain in the head; raves much at night. In the evening, convulsions occurred; the child screamed violently, and died soon afterwards, having apparently suffered much pain up to the moment of her death.

Post Mortem Examination. Feb. 27. Thorax.—Pericardium greatly distended, displacing both lungs to either side; interior thickly coated with masses of lymph, placed layer upon layer, with thick pus in the interstices; adhesions existed round the base of the heart, but the apex was free. Pleuritis on the left side; pus in the areolar tissue of the posterior mediastinum. **Head.**—Patchy vascularity of the pia mater over the right hemisphere. Arachnitis; pus smeared extensively over the surface of the brain; grey substance of the convolutions, in several situations, injected and softened. No caries of the temporal bones.

Remarks.—For the first two days we had regarded this case as one of meningitis, and had treated it accordingly. On the third day after admission, the head symptoms were relieved, but direct evidence existed of pericarditis. The question then arose, Had the case been primarily one of pericarditis, which had been masked by the disturbance of the cerebral functions?. The doctrine of probabilities was favourable to this view of the case, but a rigorous investigation of all the phenomena satisfied me, that the cerebral symptoms were not of that spurious class which functional disturbance alone may produce.

On this point the diagnosis must depend in any doubtful case; and I would say, that functional disturbance, under such circumstances, may give rise to delirium, in all its forms, to sleeplessness, and even to coma*—to any of the symptoms, in short, of disordered intellect, but it will not produce those symptoms which more directly indicate meningeal inflammation, such as retraction of the head, with inability to flex it from rigidity of the nuchal muscles, or convulsions.

The case now detailed, I have little doubt, is to be regarded as one of "diffuse inflammation;" and in the account of the *post mortem* appearances, we recognize two characteristics of such cases; 1, a tendency to inflammation of several serous membranes (in this case the pleura, pericardium, and arachnoid were implicated); and, 2, a disposition to the effusion of pus; pus was found in the pericardium, on the brain, and in the posterior mediastinum.

There are other points of interest in the case also deserving of attention, such as the remarkable alternation observed between the cardiac and cerebral symptoms; the brief duration of the pericardial friction, owing, probably, to pus ultimately becoming effused. But these I pass over without further comment, my principal object having been to exhibit the combination of cerebral and carditic inflammations, in contrast to the much more common occurrence of functional cerebral disturbance, supervening on inflammation of the heart, or pericardium.

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* *Vide* Todd's "Lumleian Lectures," *Medical Gazette*, May 3, 1850.

Case of Burn from Lightning, with Remarks.

BY CHRISTOPHER FLEMING, M.D., M.R.I.A.,

SURGEON TO THE RICHMOND SURGICAL HOSPITAL.

Anne Early, aged between 10 and 11 years, was carried to the Richmond Hospital on the morning of Saturday, the 30th of June, immediately after the occurrence of a terrific thunder storm. The mother stated that her child was burned by the lightning, and that she had been in bed with a young woman who was then lying dead from the effects of it.

On examination, several large blobs of vesication were found on the external and anterior upper third of the right thigh; and, with this exception, no other injury was visible. The mother would not leave the child in hospital at the time, but removed her there at my request in the course of the day. At that time (about twelve hours after the injury) the number and size of the vesicated patches were increased, and one or two, as large as a shilling, were to be seen on the outer side of the corresponding arm. No other local mark of injury presented itself. There was a good deal of constitutional disturbance, but yet not more than could be accounted for by the circumstances of the accident. The pulse was quiet; there was thirst, and general nervous irritability existed. In the progress of the case, much surrounding inflammation supervened, especially in the thigh and adjoining glands; but all was controlled by ordinary treatment. The burned patch on the arm healed by desquamation; the vesication on the thigh passed into suppuration, and an irregular, superficial, and painful ulceration ultimately occupied the surface of the cutis. At the end of ten days, however, cicatrization took place, and the child left the hospital.

Remarks.—The above case appears to be worthy of record, as well from its comparative rarity of occurrence, as from its history, and its connexion with the fatal case alluded to. I ascertained the following particulars on a personal inquiry. The details may be instructive to the medical jurist, and to the scientific investigator. They are as truthful as I could collect them, and they are divested of any exaggeration.

About half-past one o'clock on the morning of Saturday, the 30th ult., at which hour the thunder storm was at its height, the mother of the little girl, whose case I have given, was alarmed by the muffled voice of her child crying out that she was burning. She rushed over to where the child lay in bed, and grasping her in her arms, carried her to the middle of the room. As soon as she could she procured a light, and proceeding to the bed to see the young woman with whom her child had been sleeping, she found her lying on her left side, perfectly motionless. She gently turned her on her back, and had recourse to the ordinary efforts amongst the poor to revive her, but without avail; she was dead. It would appear that her transit from life to death was as rapid as it was painless, she not having uttered a moan or groan, audible, at all events, to those in the room, of whom there were many. The house was comfortable, although in a lane. It was three stories high, the rooms were of the ordinary size for such, and they were cleanly, and recently whitewashed. In the corner of the front room, on the drawing-room floor, near and to the left of the fireplace, lay the poor young woman who was struck by the lightning. She was about 25 years of age, was married, bore the outline of good health, and contemplated leaving for America, to join her husband, on the following day. She had an ordinary night-cap and night-chemise on her; her countenance betrayed no disturbance of features indicative of any struggle; her eyelids were closed, as if in tranquil sleep, the pupils rather contracted than otherwise; her lips were gently approximated, and retained, at this time, their ordinary colour, though perhaps less vividly. Her right eyelashes, eyebrow, and hair on the corresponding side of the face and head, were completely singed. The aspect of this side of the face presented the ordinary appearances of the effects of superficial scalds or burns, and similar effects were traceable along the same side of the trunk, as far as the upper and outer part of the thigh, where the burn had been so severe as to char the skin to about the breadth of the palm of the hand; in this immediate spot the shift was completely burned, and no other traces or marks of injury, or stains of blood, were discernible. The bed upon which the poor woman lay was of ordinary straw, the bedstead, about three feet in width, by six or so in length, was low, and a temporary foot-board was fitted against it, one of the large iron nails supporting which had been driven into the corresponding wall, right up against which the bedstead was secured. When *in situ*, this bedstead thus occupied the space on the right hand side, between the door, on entering the room, and the fireplace.

There was a good chimney-piece, there were fire irons and a metal fender, and as well as I could learn, none of these were disarranged. On endeavouring to ascertain the direction which the flash of lightning took, from the very unconnected and exaggerated accounts given, it appeared to have struck the slated roof, and to have entered the partition wall between the back and front bedrooms, scattering the plaster about, and, in its course, dashing down some framed prints, of the class usually found amongst the poor. Now, as if directed by one of the picture nails, it perforated the partition wall by a large hole, similar to that bored by a bell-hanger, and entered the back bed-room. Here, lay obliquely against a press, the metal axle of an ordinary jaunting car or cart, its lower extremity resting upon the floor, directly above the corner corresponding with the foot of the bed in which the destroyed woman lay in the room underneath. Tearing through the ceiling, it met in its course the pendulum of an alarm clock, and rolling it up into a ball, would seem to have been attracted by the large nail in the footboard above alluded to, and to have shot through the poor woman, or rather alongside of her, and to have escaped by the fireplace up the chimney, singeing in its course the little girl as she lay on the inner side of the bed. I may remark that the hands of the stopped clock pointed to the fatal hour of half-past one, at or about which, I was up and in my study, having been awakened by the thunder and by the rain, which was then pouring down in torrents.

The following extracts from *Saunders' News-Letter* of the 2nd July in reference to this death by lightning, cannot be considered inapposite:—"At the time of the occurrence, the atmosphere was surcharged with electricity, and the sulphurous smell in the air was so oppressive, that it was described by the police on duty as almost suffocating, whilst each flash presented the appearance of a sheet of fire. The weather on the previous evening was most sultry, and although at ten o'clock the tide was fully in, there was scarcely a breath of wind stirring. Shortly after that hour, slight flashes became visible in the outskirts of the city, which increased in vividness and frequency until twelve o'clock, when the lightning assumed an appearance rarely witnessed out of the tropics—double, treble, and, even it is stated, quadruple flashes following each other with great rapidity, and with truly deafening peals of thunder in the intervals. At a quarter to two o'clock, the rain came down in literal streams, which continued for some time; a short pause ensued, after which the torrents descended with renewed violence, and only ceased after day-break. The scene along the river is described as having been grand, but truly awful. The sailors had to leave their ships, and take refuge on shore, the vessels, owing to the numerous objects of attraction on board, in the shape of anchors, &c., appearing at times to be encircled by sheets and darts of flame."

Doubt must necessarily exist as to the exact direction which the electric fluid may have taken in the cases under notice, and also as to the point at which it may have entered the house. Such questions I acknowledge my incompetency to entertain, much less to decide on. Perhaps, the more pertinent reflections for the surgeon are, the manner of death in this class of injury, the local effects produced by such, and the phenomena they may present. The history of the fatal case given does not tend to remove the difficulties which yet exist respecting the two most approved theories advanced, as to the manner of "Death from lightning." The theory of Sir Benjamin Brodie is not nullified by the placid countenance of the woman found dead, or by the natural position in which she was found lying; neither, on the other hand, is the instantaneous destruction of the vital principle, as advocated by Hunter, necessarily supported by the appearances present and subsequent—appearances familiar to all. Perhaps, the blending together the theories of these two great men may tend to solve down some of the existing difficulties, and that if an instantaneous extinction of vitality does not take place, but, on the contrary, that the functions of the brain are those on which the electric shock exercises its primary influence, an instantaneous destruction of the vital principle in every part of the body, partial or total, then superadded, must momentarily destroy the vital spark. The intensity of heat developed is proved by the local effects. Vesication in the living child was almost instantaneous, and absolute charring was equally rapid in the woman. The absence of any appreciable amount of burning of the clothes or covering is not novel, and, perhaps, might be accounted for by absolute exposure of the parts of the bodies injured, from the sultry state of the atmosphere.

A reference to the valuable remarks of my friend, Dr. Beatty, in the Encyclopædia of Practical Medicine, under the article, "Persons found Dead," will prove most interesting and most instructive to those who may consult it. It has been the principal source of my information; and I may add, that I gave him the opportunity of seeing the cases which have induced me to make this communication.

Reviews.

Bericht über das Kinderhospital in München. Aus dem Vortrage des Hrn Dr. Hauner am Schlusse. des letzten Studien—Semesters.—(*Journal für Kinderkrankheiten.*)

Report of the Hospital for Children in Munich. From Dr. Hauner's Lecture at the Close of the last Session.

Dr. Hauner, the learned author of this report, has presented to the profession a considerable amount of most valuable information on a subject which *ought* to possess for the practical physician the highest interest. There is no subject, however, connected with medicine, which may be said to receive, in general, so little attention as the diseases of infantile and early life. We may naturally ask, why is this the case? Is it that this class of diseases is more easy of recognition individually, or that having recognized the disease, the treatment and general management are fraught with less difficulty than is experienced in dealing with the maladies of adult life? We affirm that to treat successfully the diseases incidental to the early periods of life, requires a more extended knowledge and higher power than are even necessary in the investigation of the diseased states presenting themselves in persons who are capable of rendering us much and valuable aid by accurately describing their sensations. This fact is too obvious to induce us to dwell at length upon it, or to adduce arguments in support of that which must be admitted on all hands.

Dr. Hauner informs us that the hospital for children at Munich has been eight years in existence, and that since 1851 it has become an educational establishment, and has attracted a large number of zealous students, among whom were many physicians. The value of the institution may be judged by the report.

From the first of August, 1853, to the 1st of August, 1854, 1929 children were treated, of whom 317 were in the hospital, and 1612 in the ambulatorium. Children under one year, 641; from one to three, 448. From three to six, 362; from six to twelve, 478. Of legitimate children, 1338; of illegitimate, 591; 943 were males, and 986 were females. For the last six months the children who were reared by hand, and those who received the breast, were noted; the first category comprehended 202 children, of whom 77 received the breast partly, but were also in part nourished artificially; 125 did not receive the breast at all. The mortality only amounted to 14 of the 317 admitted into the hospital; 13 were dismissed not cured, and 57 left the establishment only in an improved state of health.

The records of the Ambulatorium show 175 deaths; atrophie was the cause of death in 25; 8 died of pneumonia; 6 of tuberculosis of the lungs; 5 of dysenteric colitis; 5 of granular meningitis; 3 of croup; 2 of noma or cancrum oris. —— Epidemical diseases were not prevalent among children during the year, until the last few months. Hooping-cough and measles appeared in a sporadic form. For many years, it has been observed in Munich that hooping-cough and measles prevail together. Twice Dr. H. has observed that after an epidemic of measles, hooping-cough prevailed extensively, and twice he noticed the measles follow hooping-cough; both diseases are nearly related to each other, and the same atmospheric constitution seems to cause their epidemic appearance. Hooping-cough may, then, be correctly classed among diseases of the respiratory organs, and not be considered a neurosis. Of malformations and congenital diseases, there were 39, of which 8 were adhesio linguæ; 6 hydrocele and hernia;

2 struma congenita; 2 malformation of hands and feet; 1 atresia vaginæ; and 1 nævus vascularis. The subject of the last disease proved the excellent effect of the treatment by vaccination. Lymph was introduced in the ordinary way, not merely around the nævus, but into the middle of it, by means of 12-15 incisions, and the result was most successful. The nævus disappeared with the pustules, which had formed themselves into a raised mass over the eyelid (which was the seat of the disease), and caused much apprehension to the parents; the violent inflammation was merely treated by cold applications, and oiling the swelled parts. This is the third case in which erectile tumours were perfectly cured by this treatment. The beautiful cicatrix is not to be considered in comparison with the striking deformity. Of acute cutaneous diseases, there were 91; 57 of measles, 21 of modified small-pox, 6 of febrile urtecaria. Of chronic cutaneous diseases, 155; 59 of these cases were scabies, which were cured in from one to two days, surely, and without relapse. Of diseases of the mouth, &c., 100 cases. Of diseases of the stomach and intestines, 430. Of diseases of the air passages, 206, namely, catarrh, acute and chronic, 61; pneumonia, 27; hooping-cough, 87; laryngospasmus, 8; primary and secondary croup, 10. Of diseases of the heart, 4, one was a case of rheumatic myo- and pericarditis in a girl of eight years of age. Of diseases of the liver, 10; of diseases of the kidneys, 2; of the bladder, 4; of diseases of the organs of generation, 15; of diseases of the thyroid gland, 4; of the cellular tissue, 17; of the ear, 14; of the joints, 27; of the brain and spinal marrow, 79. Of specific diseases, 394, of which 40 were syphilis, 1 scirrhus, and the remainder struma and rachitis. Of diseases of the eyes, 139—the greater number of which were strumous—there were 10 cases of ophthalmia neonatorum, in which the treatment by lapis infernalis proved rapidly efficacious. There were 158 surgical cases.

Dr. Hauner concludes his summary by stating:—"I have not now time to make a very minute report, as the quickly increasing cholera has surprised us at the close of the session. It is my intention, during the next session, not only to explain to you the cases most worthy of notice, but also to communicate to you the results of my investigation into the states of the atmosphere which exercise such a decided influence on the diseases of children. Then the experiments which I am performing on the pulse, the respiration, and the skin, will be so far advanced that I shall be able to communicate to you and to publish much which is valuable on the subject."

In concluding the notice of this report, we may be permitted to give expression to our anxious wish that a similar institution were established in our city, in which the children of the poor might be treated, and clinical instruction imparted. Although still without a special hospital for the diseases of children, we possess, however, an establishment of incalculable value in the "Institution for the Diseases of Children," originally founded by the exertions of Sir Henry Marsh and Dr. Charles Johnson, who for many years gave this dispensary the advantage of their professional services, and in which, from that period up to the present time, excellent clinical instruction has been given. Great as the benefits are which this institution has conferred on a most interesting class, we must, nevertheless, admit how incomparably superior an hospital is ever found to be, in comparison even with the most admirably conducted dispensary.

SELECTIONS FROM BRITISH AND FOREIGN JOURNALS, &c.

Case of Popliteal Aneurism, treated by Compression.

This case, which was treated by Mr. Erichson, in the University College Hospital, was lately brought before the North London Medical Society, by Mr. J. Laurence. The details of the case were briefly as follow:—

The patient, a man, æt. 42, had been formerly a postboy, but had not been in the habit of riding much for the last twenty years. Three months before admission, he experienced "a weakness" in the left ancle and knee, followed in three weeks by a throbbing pain in the ham. The tumour was of large size; the leg was swollen, and the veins enlarged and tortuous. Compression, with two points of pressure, was employed. The period of compression occupied six weeks. A sudden attack of severe pain was observed immediately before the pulsation in the sac ceased. At 2, A.M., the patient was awakened from a sound sleep, by a sensation which recalled to his mind an electric shock he had once taken; he fell asleep again; and on relaxing the acting tourniquet, felt the pulsation in the ham quite gone, though he had felt it the night before. In the morning, the tumour was found solid and pulseless, and over it a collateral vessel was found beating.

Some good practical remarks on the pathology and treatment of this disease are appended, and the subject of compression is fairly dealt with. Mr. Laurence thinks that in a case like the one detailed, where there is much enlargement and tension of the leg, with œdema, and a varicose condition of the veins, gangrene is much more likely to follow ligature than compression. "One way," he adds, "in which compression guards against gangrene is, that should any tendency to gangrene show itself, we have at once the means of getting rid of its cause, by relaxing the pressure; whereas the ligature of the vessel is a thing done, not to be undone. The large size (of the tumour), and utter want of consolidation, are no objections to compression."

The author then refers to the sudden accession of severe pain which preceded the consolidation of the sac, and which has been observed in other cases, as in a case of Mr. Liston's, in 1843. In case No. 22 of Bellingham's series, compression had been discontinued, the sac having solidified, but not lost its pulsation, and the patient returned to the country, where, whilst riding a spirited horse, he felt great pain in the knee; the pain increased towards night, and the next morning the pain was gone. In a case reported by Hodgson, a subclavian aneurism underwent spontaneous cure, and the consolidation of the sac was preceded by the most intense pain and suffering, with symptoms of suffocation.

As to the objection so often made against compression, of its tediousness, Mr. Laurence observes that great variety is, no doubt, observed in different cases, but he adds, "leaving out of consideration all cases that took less than a week, or more than 60 days in their cure, I find the mean period to be 28 days. Tuffnell, taking all cases into calculation, makes it 25 days; but in truth, a reference to reported cases shows that cases of extraordinarily prolonged cure are *much fewer* in number than those of extraordinarily accelerated cure." Thirteen cases are stated as having been cured in less than seven days, one in seven hours (Dr. Hutton's case), whilst in four of the reported cases the cure occupied more than sixty days.—*Lancet.*

Luxation of the Cervical Vertebræ.

But for the circumstantial way in which the following "morceau" is transcribed into the *Gazette Medicale*, from a German cotemporary, we would be inclined to regard it as a kind of surgical hoax. The article mentions four cases of luxation of the cervical vertebræ reduced by a kind of hanging process. Lest our readers should think we are indulging in a joke, we shall give the statement as we find it in the French journal:—

"M. Martini has had the rare opportunity of seeing, in a short space of time, four cases of luxation of the vertebræ of the neck. The luxation seemed to have occurred in the four cases between the third and fourth vertebræ. The accident was characterized by a depression of the muscles of the nape of the neck, on one side, by a prominence of the same muscles on the opposite side, by the altered position of the head, and by a difficulty in moving the neck."

Pains in the neck and back, and in both upper and lower extremities, are the only symptoms mentioned as attendant on so serious a lesion!

The author first tried, but ineffectually, "the usual means of reduction" (what they are is not mentioned, and we freely confess our total ignorance of such); extension made from the head was very painful and useless. The author then conceived the (bright) idea of suspending the patient, causing him to be elevated in the air slowly and cautiously by a strong man. (!) "This man applied his hands to the sides of the head, and raised it, and then the body, completely off the ground." We fully expected to read that the experiment had proved fatal, but learned with astonishment that "as soon as the feet began to leave the ground, the patient felt a 'craquement' in the neck, and was immediately relieved." The operation, says M. Martini, must sometimes be repeated on several successive days, in order to obtain complete reduction. Complete success was obtained in the four cases, and the patients were promptly cured!

In conclusion, we are told that "there is no occasion for being in a hurry;" after several days have elapsed we may be able to reduce the luxation, "if not at once, at least after a certain number of suspensions."

We do not think the editors of the *Gazette Medicale* should have allowed such absurd, but, at the same time, dangerous opinions into their pages without commenting on their absurdity. There is here, it occurs to us, a revival of the somewhat dangerous, and therefore exploded amusement formerly practised on children, called familiarly "seeing London." The proceeding was thought to endanger the ligaments of the first and second vertebræ, and so lead to luxation and sudden death. Can our friend be a homœopathist, and on the principle of "similia similibus," &c., recommend as a cure for a luxation what is thought potent to produce one? We only hope he may never meet with a real luxation to try the hanging cure; if he does, there is a likelihood of some one else being hanged besides the patient.—EDS. DUB. HOSP. GAZETTE.

Purulent Infection of the Blood.

M. Bonnet recognizes three principal elements in pyæmia—1. The penetration into the blood of pus globules. 2. The absorption of fœtid products. 3. The diminution of the power of generating animal heat. From the observations by which the author seeks to prove these three points, he concludes that the absorption of pus, and of putrid matters, may take place without being followed by pyæmia, and that this affection is the result of the inability of the system to get rid of the pus or putrid matters by which it is infected; hence all the causes, according to this view, which induce the supervention of purulent infection, do not act by inducing the absorption of pus, but by preventing its elimination.

From experiment and clinical observation, M. Bonnet announces the following treatment as the most efficacious. It consists in all the hygienic means which favour elimination, or prevent the influence of cold, but especially in local cauterization. This is to be done either by means of the chloride of zinc (*pâte de Caucoin*), or of the actual cautery. The former to be employed in the case of a superficial wound; but in the case of amputation, with secondary abscesses in the stump, and when the medullary canal is to be acted on, M. Bonnet has recourse to the actual cautery.—*Gazette Medicale.*

Case of Transfixion of the Chest, from Side to Side, by a sharp Stake. Recovery.

This remarkable case is communicated to the *Journal de Medecine* of Bordeaux, by Dr. Lassaigne, surgeon of the 11th regiment of the line. When we consider the extreme danger of penetrating wounds of the thorax, the recovery of the patient is certainly surprising.

Case.—A soldier was employed in gathering cherries, when the branch of the tree on which he rested his weight broke, and he fell a height of several feet; his trunk coming horizontally on the stakes which protected some vines placed beneath, he was literally spitted.

Dr. Bax, one hour and a half afterwards, found the wounded man lying on the ground, with the chest pierced from side to side by the stake; the point had entered the intercostal space between the seventh and eighth ribs on the left side, four or five fingers' breadth below the nipple, and rather behind it, and had come out between the fourth and fifth ribs on the right side, behind the angle of the axilla, the point projecting from the chest to the extent of fifty centimetres. The wounded man retained all his senses; his countenance did not indicate any great suffering; he only complained of the weight of his head when it was not supported, and of a difficulty in moving his arms; voice natural; no cough; apparently no disturbance of either respiration or circulation; no indication of hæmorrhage either externally or internally.

Dreading hæmorrhage, when no assistance was to be had, M. Bax was unwilling to remove the foreign body on the moment, and accordingly the patient was removed to an hospital in the neighbourhood. When placed in bed and undressed, a portion of the shirt was found to have been carried into the thorax, forming a kind of sheath around the stake, for a considerable distance. The stake was extracted with ease, the sheath formed by the fold of the shirt seemed to facilitate the operation. This was on the 3rd July.

Nothing unusual was observed subsequently, except the occurrence of emphysema, which extended upwards to the neck; there was no cough or evidence of internal hæmorrhage.

Intense inflammation of the side, and of the chest generally, supervened, but yielded to active treatment. On the 6th July an improvement had already taken place, and the wound on the left side had united by the first intention. The improvement steadily continued, the wound on the right side subsequently closed, and about the 25th July convalescence was established.

The patient was subsequently presented to the Society of Medicine of Bordeaux; after examining the wounds, the members agreed in thinking that the stake had passed through and through the lung.—*Journal de Medecine de Bordeaux.*

Aneurism of the Superior Palatine Artery.

M. Teirlinck.

This surgical curiosity was met with in the case of a man, æt. 74. The tumour occupied the roof of the palate, which bled so frequently that the patient was much exhausted. The tumour was soft, elastic, and pulsated synchronously with the heart, alternately expanding and diminishing. Its cause was unknown, and it had lasted for three weeks. The actual cautery was employed, the slough separated in eight days, the hæmorrhage did not recur, and a perfect cure resulted.—*Gazette Medicale.*

On the Glucogenic Function of the Liver.

The views of Claude Bernard, on what may be termed the "glucogenic function" of the liver, and of which he is the discoverer, having been called in question by M. Figuier, a committee* was appointed by the *Academie des Sciences* to investigate into the matter. Their report has lately been laid before that body, and is altogether confirmatory of the theory of Bernard. The question at issue may be thus stated:—It had been announced by M. Claude Bernard (conjointly with M. Barreswill), that a considerable quantity of sugar existed in the liver. Following up the investigation, Bernard showed that this substance existed in the liver of all animals, and that its presence was consequently a proof of the nature of the functions performed by that organ.

So far these novel statements of Bernard's were not disputed by any one. But whence came the sugar which is so constantly found in the liver? How does it leave this organ? What are its uses? On these points physiologists no longer agreed.

Bernard believed that the sugar was *formed in the liver*. He did not deny that sugar was occasionally formed in the process of digestion at the expense of amylaceous substances; but independently of this intermittent supply, by which glucose might get into the venous blood, there was another permanent and special source of sugar, viz., its formation in the liver itself. The proof of this was the absence of sugar in the vena portæ of an animal fed on animal food exclusively, and the presence of sugar in the hepatic veins of the same animal. M. Figuier adopted the opinion formerly announced by M. Mialhe, viz., that the liver, instead of manufacturing sugar, *separated it from the blood*, excreting that substance, formed by digestion, where it existed in excessive quantity.

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* The members of the committee were—MM. Dumas, Pelouze, and Rayer.

Bernard's views were supported by four alleged proofs—1. The constant presence of sugar in the liver of carnivorous as well as herbivorous animals (a fact first communicated by Lehmann). 2. The constant presence of sugar in the hepatic veins. 3. Its constant absence in the blood of the vena portæ of animals fed on animal matter. 4. The temporary appearance of sugar in the blood of the porta during the assimilation of saccharine substances.

The reality of these statements was examined into by the committee. Statements 1 and 4 were admitted by all. The question was then narrowed down as to the presence or not of sugar in the blood of the vena portæ. On this point the statements of the committee were decisive. "They never found an appreciable trace of sugar in the blood of the vena portæ of a dog fed on raw meat, whilst under the same circumstances the hepatic veins contained sugar in notable quantity." "Hence," the report adds, "all the facts announced by our colleague, M. Bernard, relative to the function attributed to the liver by him, have been verified by us, and we cannot but admire the distinguished talents of the learned physiologist who first announced this discovery."—*Report of the Academie des Sciences, June* 18, *in the Gazette des Hôpitaux.*

On the Employment of the Compounds of Iron and Manganese.

M. Burin (*Gazette Medicale de Lyons*) speaks very highly in favour of the compounds of iron and manganese in all cases where ferruginous preparations have hitherto been alone employed, as in anæmia, chlorosis, &c. Numerous authorities are quoted, who have borne testimony to the superior efficacy of such compounds in practice, whilst the theoretical argument is strongly urged, that manganese in combination with iron exists in the blood in the normal state. In the mineral kingdom, M. Burin observes that manganese is usually combined with iron, and that the same substance is met with in the ashes of most of the vegetables which contribute to the nutrition of man and other animals. The researches of Liebig not only proved the existence of manganese in the blood, but went to show that it should be found as well in most of the animal tissues. Accordingly, manganese has been detected in the bones, by Berzelius, Bibra, and Marchand; in the hair, by Vauquelin; in the cuticle, by John; in the gastric juice, by Gmelin; in the urine, by Lassaigne and Sprengel; and very recently in the sweat and in the urine, by Messrs. Viale and Latini of Rome.

Pneumonic Catarrh of Infants. M. TROUSSEAU.

Diseases of the lungs present very different characters in infants, according as the children happen to be newly born, at the breast, or growing up. The lung of the newly-born infant becomes hard and impervious to air, hepatized, as in the third stage of pneumonia in adults. This state of impermeability of the lung has been described as a *return to the fœtal state.* In a physiological point of view, however, I must declare this to be quite erroneous.

From the first month after birth to the fourteenth, infants are subject to a pulmonary inflammation, called lobular or infantile pneumonia. In this disease the pulmonary catarrh is the chief complaint; the pneumonia is secondary; so in place of calling it catarrhal pneumonia, a name given to it by several practitioners, I prefer the more logical and expressive name of pneumonic catarrh.

Pneumonia is an acute affection, which either resolves quickly or kills rapidly. There is, as it were, a great battle, the issue of which is soon decided on one side or the other. Catarrh (bronchitis), on the contrary, is a series of skirmishes; the attack diminishes one day to be augmented on the morrow, and the child whose lungs are repeatedly attacked, either in the same or different parts, generally succumbs.

Pneumonic catarrh is most frequently caused by a simple cold, a slight febrile attack, or coryza. The mother of the child, although the most affectionate and anxious, sees no cause of uneasiness. Suddenly the fever is lighted up, great oppression comes on, and the child presents soon most alarming symptoms. The face becomes congested in a remarkable manner, the cheeks and lips are livid, the skin is hot and very dry, the dilatation of the alæ of the nose very considerable and almost constant; the epigastrium is retracted towards the vertebral column, the diaphragmatic belt becomes more marked, forming what is called the *peripneumonic fissure.* Orthopnea increases; the pulse gains an extreme frequency, rising to 120, 140, or 160 in the minute. Percussion is a mode of exploration both difficult and uncertain in the diseases of infancy. If, however, the hand be applied flat upon the thorax of the child while crying, it will feel the vibration of the voice much more distinctly upon the diseased than upon the healthy side. When about to auscultate the chest, care must be taken not to alarm the infant; it should be placed upon its nurse's knees, and then the physician can apply his ear to the posterior and lateral regions. A sub-crepitant rale is most frequently heard, sometimes preceded by a mucous or sibilant rale; it is not rare to hear crepitation as fine as in the adult. Bronchial breathing is heard during inspiration, but chiefly during expiration; but it has neither that dryness nor clearness which we observe in the adult; it is heard most frequently not altogether at the base, but at the superior part of the inferior lobe of the lung. The presence of the souffle can perhaps be determined in four or five different parts of the chest. The signs furnished by auscultation are very changeable; thus you may not find to-morrow, in a certain part, the souffle which you heard this evening. This arises from the principal bronchial tube leading to this part of the lung being blocked up with mucus, and thus the air is directed to other parts. In many cases we know but too well that the disease is both of long duration and liable to frequent relapses. A pneumonic catarrh remains fifteen days, a month, six months, or even more. During the course of hooping cough you may have acute attacks of it five or six times; never entirely ceasing, the malady becomes chronic, an important differential character from pneumonia of adults.

The anatomical lesions are well marked; besides the inflammation and tumefaction of the bronchial mucous membrane, we see a number of small indurated lobules, between which the tissue of the lung is healthy. The surface of the organ presents a marbled appearance. Independent of these indurated lobules which invade sometimes a portion of a lobe, sometimes the whole lobe, we remark other lobules of a violet red colour, indicating a pneumonic inflammation of the first degree, whilst here and there these masses are harder, and form projections, when the lung is collapsed. The microscope discerns globules of pus in these red lobules. In fine, we find lobules of a yellowish colour in the third stage of inflammation.

Pneumonic catarrh is followed by a special lesion, viz., pulmonary abscess, little cavities filled with pus, which in a single lung sometimes amount to the number of 100, 200, or even 500. It has been supposed that these pulmonary abscesses are nothing more than the dilated vesicles of exaggerated emphysema; but I think that the anfractuosities which are seen in these cavities arise from a number of vesicles much broken up. It is a difficult point often to determine between pulmonary phthisis when the vesicles are filled with pus, and the third stage of pneumonia.—*Gazette des Hôpitaux, July 5*, 1855.

Adulteration of Oils.

M. Mailho (*Comptes Rendus*) has proposed a simple means of detecting the adulteration of fixed oils with those obtained from the seeds of cruciferous plants, such as colza, rape, camelina, mustard, &c., depending on the existence of sulphur in those oils, and its well known action upon the salts of silver and lead, which it immediately blackens. He boils 23 to 35 parts of the oil in a porcelain capsule, with 2 parts of caustic potassiureted alcohol and 20 parts of distilled water. After a few minutes' ebullition, the entire is thrown on a previously moistened filter, and the alkaline water which flows from it is tested by paper impregnated with nitrate of silver or acetate of lead, which speedily denote the presence of sulphur. By boiling the oil and alkali in a silver vessel, it may be coloured directly; and the action is very appreciable, detecting the presence of 1 per cent. of those oils when added to any other fatty oil, such as linseed.

Remarks on some New Properties of Glycerine. By E. W. Davy, M.B.

Dr. Davy, in the *Chemist* for July, has published some interesting remarks on the property which glycerine possesses of acting as a reducing agent upon many metallic salts, in a manner very similar to the effects produced by grape sugar. The action is especially evident when the solution is boiled, and Dr. Davy appears inclined to attribute it, at least in some instances, to the formation of active deoxidizing substances from the glycerine at the high temperature employed, for he states that it is not, generally speaking, till all the water present, either in the salt or in the glycerine, has boiled off, and the glycerine begins to decompose, that the reducing action takes place. Practically, these observations are of importance to the profession, for glycerine being now employed extensively in many ways in pharmacy, it will be well to recollect the reducing tendency of this substance, and to prepare metallic solutions with it, whenever they are desirable, freshly, and from pure glycerine, either by solution in the cold, or at as low a temperature as possible; it will also be worth inquiring how far the use of glycerine, as recently proposed, for the purpose of preparing the pill masses, and preserving them in a soft condition (for which purpose it is admirably adapted), will be expedient, when chemical preparations, as corrosive sublimate, nitrate of silver, &c., are liable to be prescribed, with these preparations.

On an easy Method of purifying Sulphuric Acid from Arsenic. By A. Buchner.

Arsenious acid is, as is well known, easily changed by the action of hydrochloric acid into the much more volatile chloride of arsenic. If arsenious acid be dissolved in hydrochloric acid, or if a liquid containing arsenious acid be mixed with hydrochloric acid, and then a sufficient quantity of concentrated sulphuric acid be added, chloride of arsenic, as Liebig has shown, will separate out in oily drops and as such may be distilled off. Chloride of arsenic boils at 132°, and volatilizes with hydrochloric acid vapour much under its boiling point, while concentrated sulphuric acid boils at 325 to 327 C. I am not aware whether these facts have been employed for purifying sulphuric acid from arsenious acid, but experiments have shown me that they form the basis for such a method of purification. In fact, if sulphuric acid containing arsenic be mixed with a little hydrochloric acid and burned, or better, if a moderate stream of hydrochloric acid gas be passed through the heated sulphuric acid, all the arsenic is rapidly removed as chloride of arsenic. I have purposely dissolved a large quantity of arsenious acid in sulphuric acid, and then treated it in this manner. In a short time the arsenic was so completely removed, that the Marsh's apparatus gave no trace of arsenic even after some time.

After passing the hydrochloric acid through, the heat may be continued a short time, in order to drive off every trace of hydrochloric acid, if this be necessary. I consider this process the only possible one for preparing sulphuric acid pure for chemico-legal investigations.

It is known that sulphuric acid cannot be freed from arsenious acid by rectification, because their boiling points are too near, and because the sulphuric acid is of the two the more volatile; and the precipitation of the arsenious acid out of the sulphuric acid by sulphuretted hydrogen is too unpleasant and takes too much time.

This process offers also the advantage, that any nitrous acid which may be present is removed in the form of chloride of nitric oxide.—*Liebig's Annalen*, vol. xciv. 1855.

Presence of Lead in Commercial Hydrochloric Acid.

Hainault has observed that hydrochloric acid, when neutralized, gave a copious white precipitate, which, dissolved in nitric acid, gave with iodide of potassium a yellow precipitate of iodide of lead. This chloride of lead most probably originated from the leaden vessels used in the preparation of the acid.—*Journ. de Pharmacie d'Anvers.*

Chronic Bronchitis; Treatment with Chloride of Ammonia.

M. Delvaux, of Brussels, has often employed the chloride of ammonia (sal ammoniac, muriate of ammonia), and he has been struck by the good effects which it produces in chronic bronchitis.

In more than twenty cases which he has observed during last winter, he has obtained, if not complete cures, at least very decided improvements.

Before the employment of the chloride of ammonium, which he administers in a dose from 1 to 3 grammes (about from 15 to 45 grains), in the twenty-four hours, M. Delvaux always gives a purgative, and prescribes a regimen more or less strict during one or many days. This salt produces usually a copious perspiration, and abundant urine; sometimes, after many days of its employment, a slight febrile excitement makes its appearance, which disappears when the medicine is discontinued for a longer or shorter time.

Under the influence of the chloride of ammonia, the dyspnœa diminishes, the cough becomes less fatiguing, the expectoration more easy and less abundant, and the appetite soon reappears.

M. Delvaux administers the ammoniacal salt according to the following formula, published by him in the *Presse Medicale Belge*:—

Pills with the chloride of ammonia—

Chloride of ammonia, 5 grammes.
Honey, powder of althea, of each q. s.

Make 20 pills. From 4 to 8 pills to be taken in the twenty-four hours.

Electuary with the chloride of ammonia—

Syrup of elder, 120 grammes.
Chloride of ammonia, 1, 2, 3 do.

To be taken by teaspoonfuls from hour to hour.—*Journal de Chimie Medicale.*

A new Method of using the Catheter, and instantaneous Cure of Strictures.

M. Maisoneuve communicated on May 14, 1855, to the Academy of Sciences of Paris, a memoir, in which he describes his method of catheterism, which may briefly be sketched as follows:—The author, being struck by the advantages of passing a tube over a conductor in the treatment of stricture (as practised by Mr. T. Wakley in London),* proposes, when the stricture is very narrow, to introduce a filiform bougie into the bladder, to screw a metallic instrument to the free end of it, and to push on that instrument along the canal, making the bougie recede into the bladder, in the cavity of which it is expected to bend upon itself. The instrument used may be either of those which have been proposed to dilate strictures or to cut through them. The author thinks, however, that bad coarctations should be divided from before backwards, and he operates in the following manner:—

When the bougie has reached the bladder, a grooved urethrotome is pushed onwards through as many strictures as the canal may present, the bougie bending upon itself in the bladder. Along the groove, a rod, furnished with a sharp blade at its extremity, is pushed on, and made to cut the urethral obstacles. When this is done, the grooved urethrotome is withdrawn and a second introduced, to the extremit y o which a hidden blade is attached. As soon as the instrument is fairly in the canal, the blade is protruded by means of a spring; and on withdrawing this urethrotome caché, the strictures are again fully divided. The peculiarity of the method is that the author considers that the freedom of the canal after these incisions would be prevented by leaving an instrument on the raw surfaces; he thinks that the part should be allowed to heal without any catheter, and maintains that the cure is instantaneous, as the patient is immediately able to pass urine in a good stream. The Academy of Sciences have appointed a Committee to report upon this method, M. Civiale being one of the members.—*Lancet.*

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* But first practised by Dr. Hutton, in the Richmond Hospital, in the year 1835.—Ed. D. H. G.

Treatment of old Ununited Fracture, by the Suture of the Fragments after Oblique Resection.

M. Laugier has submitted to the Academy of Sciences of Paris a case of ununited fracture of two years' standing, in which he performed the above operation. Before detailing the case, the author stated that Mr. Kearny Rodgers, in 1825, had succeeded in obtaining union by resecting the fragments of the humerus, and keeping them together by a silver wire; the patient was fifteen years old, and consolidation was obtained after sixty-nine days. Valentine Mott had a similar favourable case in 1831. M. Flaubert, of Rouen, has also operated upon the humerus; he brought the fragments together after resection by means of four waxed threads, and kept the bones in accurate contact, but union did not take place. It is to be noticed that the fragments were always sawn perpendicularly to the axis of the shaft. It was M. Flaubert who first remarked that the chances of union would, perhaps, be greater if the bones were resected *obliquely*, so as to bring them in contact over a larger surface. M. Laugier observes, with much truth, that by sawing obliquely we do not shorten the bone, and render the operation easier, less protracted, and less dangerous.

It will be recollected that the wire has been used by Mr. Stanley in a case of ununited fracture of the femur; the case was reported in the "Mirror" of this journal, and necessitated eventual amputation. (*The Lancet*, vol. ii. 1854, p. 81.)

M. Laugier's patient is a man of 41; the fracture had occurred just below the insertion of the deltoid, and the fragments had remained separated for almost two inches, the limb being quite useless. The seton had failed twice, the scraping of the ends of the fragments having been superadded at the second operation. At last M. Laugier resected both fragments obliquely, taking off so much bone as to re-establish the continuity of the cylinder. A perforation was then made through each fragment, and a ligature, composed of several waxed threads, was then passed through the orifices, and the bones kept in close approximation.

The ligature, which had been allowed to hang out of the wound, fell at the end of three weeks, and, the loop having been found entire, it was concluded that the thread must have worked its way through the bones. The arm was then put in a gutta percha apparatus, with a movable valve, to allow the limb to be examined; the suppuration never was profuse, and the sympathetic fever trifling. It may be remarked that the oblique section does not of course require the complete and circular denudation of the bones, which takes place in the horizontal section.

On the forty-second day after the operation, consolidation seemed in a fair way of formation, and M. Laugier thinks that in about one month the union will be complete. It is to be regretted that the author did not wait for the completion of the case before mentioning it at the Academy. We hope, however, that he will give the ultimate results to the professional world.—*Lancet.*

Case of Femoral Hernia, containing the Caput Cœcum, and complicated with an Irregular Obturator Artery surrounding and constricting the Protrusion. By J. SPENCE, F.R.C.S., Edinburgh.

[We copy from the current number of the Edinburgh Medical Journal, the following interesting case of femoral hernia.]

Archibal H—, æt. 49, the subject of the present communication, had been under treatment in the medical wards of the Infirmary for some time, on account of severe chronic bronchitis, and skin disease. He had suffered from femoral hernia for many years, which he had always hitherto been able to reduce by taxis, although often with considerable difficulty. On the evening of the 17th of March, I was requested by the resident physician to see the patient, as the hernia had come down suddenly about six hours previously, during a fit of coughing, was of larger size than usual, and had resisted the efforts made to reduce it; whilst vomiting, pain, and tension in the swelling had supervened. The resident physician informed me that he had tried the taxis as on former occasions, and that failing, it had also been fully tried whilst the patient was under chloroform by one of the resident surgeons, but without success; I learned, moreover, that the patient had been making constant but unavailing efforts to reduce it himself. I found him vomiting, complaining of pain in the abdomen, and with an anxious expression of countenance. The hernia, which was a femoral one, about the size of an orange, was tense, and painful on pressure. I had him put under the influence of chloroform, and judging from the state of the swelling and the previous efforts for reduction, that it would be better not to persist too much in the taxis, merely made a slight trial, and failing in this proceeded to operate. I divided the integuments over the hernia, as I usually do, by a T incision, but owing to the depth of the fat, and the bulk of the tumour, converted it into a crucial incision, to gain more room. The superficial fascia having been divided so as to expose the tumour, it was seen to be of a somewhat irregular form on the surface. On drawing the body of the swelling downwards, the falciform edge was seen, with the neck of the hernia very deeply situated. The fasciæ immediately covering the sac were next cautiously cut through, and a small flat director was insinuated *beneath the margin of the falciform edge, which was notched with the bistoury sufficiently to enable me to use the point of my finger, to guide the knife in dividing the deeper constriction.* On pressing my finger upwards, I became sensible of the indistinct pulsation of a vessel close to the constriction, and, therefore, only made a very slight notch upwards and inwards, and another directly upwards, so as to divide the stricture at two points of its circumference. This enabled me to get the point of my finger so far below the crural arch as to push the vessel upwards and divide the arch to a sufficient extent to allow of the reduction of an ordinary hernia. I then scratched through a few fibres lying immediately on the neck of the sac, and attempted reduction without opening it, but unsuccessfully. I made the less effort to do this, as the hernial contents, as seen through the thin sac, seemed exceedingly dark and tense. I, therefore, opened the sac, and gave vent to a quantity of dark bloody serum, and exposed a portion of intestine (the cœcum), tense, and almost black from ecchymosis. Anxious to avoid, as far as possible, any further pressure on the bowel, I again enlarged the division of the ring sufficiently to enable me to introduce my finger, and also to draw down and examine the portion of intestine immediately above the stricture: I now found the contents of the sac to consist of the cœcum and the lower portion of the ileum; the latter was at once easily reduced, but the cœcum, from its form and connexions, could not be so readily returned, and as, on examining it, I found a small portion of its peritoneal and muscular coats had been lacerated by the attempts at taxis, I thought it safest to make a still freer opening by dividing Poupart's ligament completely. With this view the chord was drawn upwards with a blunt hook, and I carefully dissected through the lower part of the tendon of the external oblique in a line corresponding to the centre of the femoral ring. Having fairly divided the superimposed textures, I found that there was still some constriction higher up preventing the gut being returned, and which kept it tense. On passing my finger up, I felt a tight cord-like substance encircling the hernia external to the sac, and recollecting the vessel I had felt pulsating, I at once concluded this must be the irregular obturator, whilst from the bulk, distention, and state of the protruded gut, it was equally evident this constricting cord must be divided to permit safe reduction. Accordingly, keeping the finger of my left hand within the sac, as a guide to the constricting vessel, I used the fore-finger of my right hand so as to hook it down, and brought it distinctly into view. The vessel was tied with two ligatures, and divided between them, the gut reduced, and the wound dressed and bandaged in the usual way.

I ordered an opiate to be given, and directed leeches to be applied at once, in case any symptoms of peritonitis supervened. Next day the pulse had risen to 120, and there was pain in the abdomen, and vomiting. Fifteen leeches were applied, and a pill composed of 2 grs. of calomel and ½ gr. of opium, was given every four hours. On the 20th, the abdominal tenderness and the vomiting were less; but as the bowels had not yet been moved, an assafœtida enema was administered; this produced no satisfactory evacuations; a large distending enema on the 21st also failed to open the bowels: a dose of castor oil was therefore given on the evening of the 22nd, and, on the morning of the 23rd, after another large enema of warm water, a very considerable fæculent evacuation took place with great relief. On the 24th, his general appearance was better, the pulse had fallen to 100, and the abdominal tenderness now complained of was confined to the lower part of the abdomen, and evidently due to inflammation, and threatened suppuration in the abdominal parietes. He could retain food without vomiting, and was ordered chicken soup and some port wine. He was weaker and restless on the 26th. There was considerable pain and tension at one part of the abdominal parietes, and it was thought advisable to make an incision, in case of purulent matter being confined; but the incision, though carried deeply, did not open any purulent collection. A poultice was directed to be applied. The patient continued much the same till towards the morning of the 27th, when he became worse, sunk rather suddenly, and died at 11 A.M.

Post-mortem Examination. On opening the abdomen, there were found the marks of acute peritonitis, but in a great measure limited to the right iliac and pelvic regions; lymph was effused upon the surface of the intestines, and there was a small quantity of turbid serum in the pelvis. The cœcum had regained nearly its normal position and appearance, retaining only slight traces of ecchymosis; the abraded part of its peritoneal and muscular coats, however, was as distinct as when first seen during the operation, and no attempts at plastic reparation seemed to have taken place; the lower parts of the ileum were also free, except a portion about three inches in length, which was thickened, and adherent to the parietal peritoneum in the neighbourhood of the wound.

Before making any further dissection, I inserted a pipe into the right common iliac artery, and threw in some injection to distend the vessels, so as to be able to examine them more carefully afterwards.

On examining the swollen parts of the abdominal parietes, the muscular tissue was found generally thickened, and of a dense brawn-like consistence; whilst the substance of the rectus and oblique muscles was studded with numerous small collections of pus of a dirty grey colour, and which seemed infiltrated into their texture, not escaping readily when the collections were opened. There was also a considerable diffuse abscess in the sub-peritoneal cellular tissue on the right side of the bladder, at some distance from the wound. The parts more immediately concerned in the operation were removed for further examination.

On careful dissection, I found, as might have been expected from the lapse of time, that the parts were considerably matted by plastic effusion. On dissecting from without, I found the whole of the falciform process, together with the lower border of the tendon of the external oblique, fairly divided, and the spermatic cord and its investments laid bare, leaving even yet, after the contraction consequent on the healing process, a very free opening.

Dissecting from within, I found the epigastric artery of a large size, and the obturator arising from it; this latter vessel was obliterated to some extent, and diminished in size from the effects of the ligature. The ligature on its proximal end had not separated, that on the distal end had; but the injection had entered the distal portion by the anastomosing vessels, so that the course of the artery round the opening through which the hernia passed, can be readily traced. It arises from the epigastric before that vessel has ascended on the parietes, creeps slightly upwards on the outer side of the femoral ring, then curves closely around its upper border, and finally descends along its inner side to gain the obturator foramen, so as to encircle the opening at all points available for division with the knife.

I learn from Mr. Edwards, one of the demonstrators in the University, that the artery was also irregular on the opposite side, where the epigastric arose from the common femoral, passed upwards in front of the femoral vein, and on reaching the abdominal parietes, gave off the obturator so as to surround the upper part of the crural ring; unfortunately, however, the dissection has not been preserved.

[The extremely interesting and practical remarks on this case we are obliged to hold over until the next number.—EDS. D. H. G.]

Cases in which a Communication was established between the Stomach and Colon. By W. T. GAIRDNER, M.D.

The author detailed to the Medico-Chirurgical Society of Edinburgh two cases—one his own, the other Dr. Kilgour's—in which a communication existed between the stomach and colon. Dr. Gairdner had only been able to find three others recorded. The last had occurred to Dr. Combe, in which vomiting of fæces had been the most characteristic symptom; this had not occurred in the cases either of Dr. Kilgour or of Dr. Gairdner. On the other hand, vomiting of food had not occurred in Dr. Combe's case, and had been frequent in the other two. Dr. Gairdner referred to the situation of gastric disease, as the cause of these differences. In Dr. Combe's case, the fistulous opening was in the great curvature and towards the left, while in the other two the pyloric extremity of the stomach was diseased, and in one of them (Dr. Kilgour's) the pylorus was nearly impervious. There were too few facts to allow of secure conclusions being formed, but Dr. Gairdner was inclined to believe that it would be found that fæcal vomiting was to be looked for chiefly in those cases in which the pyloric opening was free, and in which, therefore, the stomach was not overloaded with its own proper contents; while vomiting of food was to be expected in the opposite class of cases. Where fæcal vomiting did not occur, the diagnosis of a fistulous communication like that which existed in those cases must always be obscure. The diminished tendency to vomit food, and the rapid emaciation which might be expected to ensue, were not characteristic; because the ordinary course of cancerous stricture of the pylorus did not in these respects differ very materially from the condition in question. If, indeed, a marked and sudden alleviation of the vomiting occurred, simultaneously with a great reduction in the size of the stomach on percussion, and with the dejection of alimentary matters half digested, while the appetite continued strong and the patient was yet not nourished, a diagnosis might be arrived at.

DUBLIN: PUBLISHED BY W. B. KELLY,
8, GRAFTON-STREET.

LONDON: S. HIGHLEY, 32, FLEET-STREET.

EDINBURGH: MACLACHLAN & STEWART.

August 1, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.
SENT FREE BY POST.
Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 14.—VOL. II. AUGUST 15, 1855. PRICE 5D.

CLINICAL LECTURE ON CASES IN WHICH THERE IS BLOODY URINE.

BY JOHN HAMILTON,

SURGEON TO THE RICHMOND HOSPITAL.

A MAN in No. 1 Ward with gonorrhœa, and who passes, much to his alarm, large quantities of blood from the bladder, led me to think a half hour will be well spent in passing in review some of the various diseases in which hæmaturia occurs.

For practical purposes they may be usefully divided into

1. Affections of the urethra.
2. Of the bladder.
3. Of the kidney.

1. *Affections of the Urethra.* Any cause producing a solution of the continuity of the lining membrane of the urethra, may cause a flow of blood from the passage along with the urine; its source is readily recognized. In virulent gonorrhœa the mucous membrane becomes so turgid that the delicate vessels give way, and the discharge is bloody; and also, when the patient makes water, the sudden distention of the narrowed passage ruptures these overloaded vessels, and the urine is more or less deeply tinged with blood. I have seen another cause of bleeding from the urethra in gonorrhœa. A young man, who suffered much from chordee, was told by some ignorant brute that if he had sexual connexion with the penis in that state, he would not again suffer from chordee. He followed this advice, and ruptured the urethra, from which there was very smart hæmorrhage, and the urine became deeply tinged with blood, and full of small stringy blood-clots. I was sent for to see another young man with frightful hæmorrhage from the urethra, and each time he passed water more than half was nearly pure blood. He thought he would cure a chordee by a way of his own, and accordingly when the penis was in a state of crooked erection, he struck it a violent blow with a heavy wooden ruler, and ruptured the urethra. A stricture formed at the ruptured spot, and it turned out a most troublesome case. A more common cause of ruptured urethra is a fall on the perineum. The fact of the appearance of blood from the urethra, and in the urine, is the surest evidence in this kind of injury that the urethra is ruptured.

I need scarcely mention the violence done the urethra by the forcible and awkward use of the catheter; or the hæmorrhage succeeding the application of the nitrate of silver in stricture, where the slough is washed off by the urine, which becomes stained with the blood flowing from the open vessels, or that proceeding from the urethra when torn by the sharp fragments of stone after lithotrity.

Now as to the second head, viz., where the *bladder* is the source of the blood in the urine, the most common example is inflammation of the bladder. Here the mucous membrane congested to the greatest degree pours forth blood; more moderate in chronic inflammation, but in acute cases often in great quantity, as in the man in the house. William Foley ætat. 18, previously healthy, was admitted into No. 1 Ward with hæmaturia. A fortnight ago he contracted gonorrhœa, and a few days before admission he became affected with great frequency and pain in making water, which was deeply tinged with blood, the last few drops being nearly pure blood, which even came away in strings. The frequency was very urgent, and the bottom of the vessel was full of tenacious slimy deposit. Here the inflammation of the gonorrhœa had spread from the urethra to the bladder, and that acutely inflamed organ had poured out the blood. You had lately an opportunity of seeing bloody urine in a little boy with stone in the bladder. In this case the source is not only from the inflammation of the mucous membrane, but the mechanical injury to it from the action of the stone. I had a gentleman under my care some time since, labouring under scurvy. In addition to bleeding gums, petechial spots, and ecchymoses or bruised looking patches over the body, he had hæmorrhage from the bladder, the urine being very bloody. In what is called fungus of the bladder, that is a malignant fungoid mass springing from the membrane, there is usually hæmaturia. Of this you will find many interesting examples in Civiale. We have lately had one in the house. The case was taken by Mr. Tyrrell. Anne Browne, ætat. 70, married, and has had children, always healthy, except occasional attacks of rheumatism, admitted into 13 Ward, March 5th, 1855, complaining of pains in the loins and inability of retaining her urine for more than ten minutes at a time; it then flows in small jets, accompanied by intense pain along the urethra, and followed by great forcing, which lasts for many minutes. She has a continual dull pain over the pubes, and a burning sensation throughout the abdomen, her features are pinched, and the countenance expresses much suffering. Pulse quick; tongue morbidly clear; urine turbid, high-coloured and alkaline; it contains blood, pus, mucus, and epithelium, with crystals of the triple phosphate. For the last few years she has been troubled with occasional difficulty of passing water, but three months since she became affected with very distressing irritation, and five weeks since she noticed that her urine was mixed with clots of blood, and for seven days she passed almost pure blood; it then ceased to appear with a diminution of the sufferings, but for the last three days the hæmorrhage has returned, and all the symptoms are as bad as ever.

These symptoms were evidently those of inflamed bladder; but as she stated that she had passed a small calculus, I naturally looked for one as the exciting cause. I introduced a silver catheter and struck against a calcareous body; a piece broke off, and getting into the urethra, enabled me to seize it with a forceps and withdraw it. It proved to be a small irregular flat piece of triple phosphate. This operation gave her great pain. A week afterwards she passed a similar piece. I explored the bladder a second time, while she was under the influence of chloroform; and undisturbed by the struggles and cries of the poor patient, I was enabled to arrive at a more decided conclusion, viz., that the disease was not stone, but a fungus at the neck of the bladder. I could distinctly make out a tumour, prominent, fixed, and rough, with a gritty, calcareous summit. A large piece of this calcareous matter loosened, and was forced by the action of the bladder into the urethra, from which I removed it as before, and found a flat, hollow, irregular, thin plate of triple phosphate, moulded evidently on the fungoid tumour. A good deal of blood followed this examination.

Besides this fungus of the bladder, distressing and hopeless as it is, there is yet another and a worse form of malignant disease, causing bloody urine, viz., cancer. Here is a drawing of a case of this kind. The bladder is large, its walls hard and irregularly thickened, the appearance of the interior is most remarkable, and unlike any thing I have ever seen. All trace of mucous membrane is gone, the whole surface being converted into cancerous warts, rather soft, in some places ulcerated, and of a reddish brown colour. There was a small quantity of bloody, turbid, ammoniacal urine, such as had been passed during life. The history of this curious pathological specimen is briefly as follows:—

Mr. V., æt. 46, about three years previously, was working in his garden, when feeling a desire to pass water, he was surprised to find that he passed some blood. He soon after suffered from pain and frequency. It was thought by several surgeons whom he consulted that he had stone, for which he was frequently sounded. When I saw him with Sir P. Crampton, he had all the symptoms of a calculus in the bladder in the most aggravated degree; frequent urgent desire to make water, every five or ten minutes; great pain and straining, with sudden stoppages in the stream. But he had, moreover, signs of another disease, for the urine, besides containing blood, mucus, and pus, was also loaded with small grey shreds, like small strings, which blocked up the urethra, at times rendering the passage of an instrument necessary, and even closing the eye of the catheter itself, so that it was necessary to inject water to clear it. The urine was also the most ammoniacal I ever smelt, pinching the nose like strong smelling salts. The agony he felt from the presence of the urine in the bladder was such and the difficulty of passing it so great, from the obstruction of the shreds, that he was constantly calling for the passage of the catheter, and finally required a medical man constantly in the house with him for the purpose. Except a lady in whom a cancer of the os uteri ulcerated into the bladder, he suffered more than any one I ever saw.

Sir E. Home mentions a case in which the urine was bloody, where an ulcer of the bladder was found that had opened an artery; in another case the top of the prostate was the seat of an ulcer. In enlargement of the prostate gland in old age, with partial or complete retention of urine, the bladder inflames and bloody urine results. I have met with another cause of bloody urine in this disease, which is well worth your attention. A gentleman, æt. 74, six or seven years before his death, suffered from occasional attacks of retention of urine from enlarged prostate, and was relieved by the passage of the catheter. He also had occasional hæmorrhages from the bladder, particularly for the last three months, during which he required the catheter once or twice daily. At last so smart a hæmorrhage took place, with such alarming general symptoms, that Mr. Cusack saw him in consultation with me. He could, with great straining, pass only a few drops of blood, while the bladder could be felt distended above the pubes. A catheter passed into the bladder brought away nothing but a little blood. The supposition was then formed, either that the instrument had not entered the bladder, or that a clot of blood occupied the entire bladder; or, that the eye of the instrument, No. 8, was clogged up with blood. An instrument with a larger eye was then passed and some water injected, it came back tinged with blood; finally, on a second introduction a couple of hours after, a pint and a-half of urine, very bloody, was withdrawn, the last part nearly pure blood and quite dark. Little relief followed; he got a rigor, followed by coma and death. You see here a plate, and also a cast of the interior of the bladder. It is very capacious and intensely inflamed, the mucous membrane of a plum colour, with deposition of brownish lymph. But the interesting part is the state of the prostate, fully explaining the excessive hæmorrhage. The middle lobe is much enlarged, as big as a small orange, projecting over the orifice of the urethra. It is split nearly in half opposite this opening, which must have been done by the catheter, which could not enter the bladder without its point striking against the prostate, the structure of which easily allows of being split or torn.

Disease of an organ near the bladder may cause blood to flow into it and the urine to be more or less bloody. I saw, in consultation with Dr. Nalty, a man about sixty who passed fæces in the urine. Wishing to wash out the bladder I injected some tepid water; after this he passed urine loaded with blood. He died a year after. A malignant stricture of the rectum was found high up, scarcely admitting a goose quill; above the stricture the bowel was dilated, with an ulcerated opening in it, leading by an oblique narrow passage between the rectum and bladder, and finally entering the latter.

With regard to the third division, where the bloody urine takes its rise in the *kidney*, I must be brief.

The presence of a stone in the kidney may cause it, particularly after the person has been jolted in riding or driving. It may occur only after the stone has left the kidney and is passing along the ureter. Disease of the kidney itself may produce it; my friend Dr. Lees exhibited, at the Pathological Society, a remarkable specimen of fungus hæmatodes of the kidney in which bloody urine was a prominent symptom. Simple inflammation of the kidney may produce this symptom. James Donnelly, æt. 36, a cabman, admitted into No. 5 Ward, a hard drinker, complains of pain in the left loin, going across the abdomen a little above the umbilicus, and down to the left testicle. He passes blood in small clots, mixed through the urine, with frequency and some pain in micturition; but the water issues in full stream. Walking or driving in a rough vehicle increases the pain of the back or belly. The pain came in the left loin a month ago; a fortnight after it extended to the belly. The urine has been bloody from the beginning. Never had gonorrhœa or syphilis.

The urine was dark-coloured, and contained reddish brown clouds of blood; the microscope detected blood globules, and epithelial scales. There was no deposit, in which respect it offered a marked distinction from the urine in inflammation of the bladder, where the blood is pure, streaked on the deposit, or mixed copiously with it. This, with the symptoms being referred to the situation of the kidney, and the accompanying derangements being evidently those of the great sympathetic nerve—vomiting, pain in the belly, and retraction of the testicle—led to a decided diagnosis of the kidney being the seat of disease. He was cupped and blistered, and given some opening medicine, after which he was put on dilute sulphuric acid. He left hospital well at the end of a week.

Direct violence to the kidney will also, as you might expect, cause hæmaturia.

Mr. R. G., in December, 1849, was thrown from his horse, which rolled over him, and hurt the loins severely, particularly at the left side, where he suffered great pain. He passed bloody urine. The surgeon in Wales, who saw him soon after the accident, gave medicine, and applied a blister with some relief; but when I saw him, about a fortnight after, he was suffering much pain in the left renal region, and the urine, on examination by the microscope, still showed blood corpuscules. Cupping and a second blister cured him.

Whatever the cause, the presence of blood in the urine is usually readily recognized, either by a general red colour, diffused as a stain through the whole urine, or by a deposit of coagula as dark as black currant jelly. When there has been sudden hæmorrhage into the bladder in large quantity, the blood coagulates, and the large coagulum is slowly dissolved by the urine, which is of a deep, dull red colour, and somewhat turbid. Small clots are passed, which obstruct the urethra, and cause partial and occasional retention of urine. The clot is sometimes so large and so slowly dissolved, that it becomes necessary to pass an instrument with a large eye, and inject the bladder with tepid water, which more rapidly dissolves it. In such cases, where the clot is long in the bladder, and slowly dissolved by the urine, there is a deposit of a very tenacious black mass at the bottom of the vessel. When the blood flows freely from the bladder down the urethra, or comes from the urethra itself, it coagulates in the passage, and long strings of clotted blood are passed, imperfect moulds of the urethra. When the quantity of blood is small, and its presence is doubtful, the microscope offers a very sure means of detection.

Case of Rhinoplastic Surgery.

BY HENRY THOMPSON, M.D.,

SURGEON TO THE COUNTY TYRONE INFIRMARY.

Patrick Daly, æt. 30, a labourer, in good health at the time, but bearing the marks of extensive scrofulous ulceration of the face from which he had suffered twelve years before, was admitted into the Tyrone Infirmary on the 13th July, 1854. The disease had long since ceased, but great deformity existed, consisting in the loss of both nasal bones, leaving large openings into the nostrils on each side, so as to present a most disgusting appearance, and further, causing great annoyance to the patient from the constant discharge of mucus, and the consequent excoriated state of the integuments around. The openings were separated from each other by the septum, the free edge of which was covered by a narrow slip of skin, about an eighth of an inch wide, whilst its sides presented a covering of mucous membrane, in a granular state from exposure. A large, smooth, polished cicatrix, adherent to the bone between the eyelids, precluded the possibility of procuring any skin for the stoppage of the gaps from the usual situation (the forehead). In addition to the deformities already described, there was a considerable degree of ectropeon of the inner half of the left lower eyelid, exposing the puncta, and causing epiphora.

As the patient was most solicitous to have something done for him, the following operation was performed, and, I am happy to say, with complete success.

The opening on the right side, I must premise, was much narrower than that on the opposite, and its outer margin, formed by the nasal process of the superior maxillary bone, was covered by skin, which had fallen inwards on losing the support of the nasal bone, and had become adherent to the under surface of the outer edge of the opening. By means of a very narrow knife, I dissected this skin off the edge of the bone, and by unfolding it, found it large enough to cover the opening, and be attached by two points of suture to the pared edge of the centre slip, which covered the remains of the septum: adhesion took place, and the defect on that side was thus remedied.

About a week after, when the union was perfectly firm, I operated on the other side, where I had a more difficult task to perform, there being no integument folded under the bone there of which I could avail myself; I had, therefore, no resource but to separate and move over a portion of skin from the adjoining side of the cheek. In order to *support* this in its new position, and *protect* it from the effects of contact with the air, and mucus of the nostril, I dissected the mucous membrane from the exposed side of the septum, and turned it down by means of a needle and thread passed through it from the nostril, so as to make it close the opening, for which it thus formed a roof, lined by mucous membrane. I then separated from the side of the nose and cheek, a portion of skin about an inch broad, dissecting it from the subjacent parts up to the very edge of the everted eyelid, and moved it over the opening already filled up by the reverted mucous membrane of the septum, the dissected surface of which was thus applied to and covered by the dissected surface of the skin, whose inner edge was then attached by fine sutures to the pared edge of the slip which covered the septum. By this manœuvre the opening was completely closed, and, at the same time, the ectropeon removed; the eyelid returned into its natural position, and the slip of skin lies without any puckering or irregularity in its new situation, where union speedily took place, and nothing remained but a narrow, scarcely perceptible cicatrix at the side of the nose, from which the skin had been removed.

Remarks.—The cure of the ectropeon in this case was not the least satisfactory result of the measures adopted, which suggests a mode of treating that deformity, as well as many others caused by contracted cicatrices, which I have since successfully adopted in another case of ectropeon affecting the outer half of an eyelid. The plan I allude to is that of making the incision in the *sound* skin at some distance from the cicatrix, and separating *this* from the subjacent parts to an extent sufficient for the purpose designed, which is then to be effected by placing the separated skin in the requisite position, and fixing it there until new adhesions form. If I do not mistake, the case I have described above affords an example of the adoption of a new principle in rhinoplastic surgery—that of *supporting* and protecting the dissected surface of the transposed or transplanted integuments, a principle of some importance, as tending to obviate the sloughing or ulceration which sometimes occurs in the centre of transplanted parts, even where the edges may have united, and one which can always be acted on to more or less extent, by preserving and folding back the edges of the opening to be repaired, instead of paring these off altogether, as hitherto practised.

STRANGULATED INGUINAL HERNIA TERMINATING IN ARTIFICIAL ANUS—RECOVERY.

BY S. CHAPLIN, M.D., F.R.C.S.I.,

SURGEON TO THE COUNTY KILDARE INFIRMARY.

Matthew Brougham, æt. 42, a middlesized man, a labourer, was admitted into the County Kildare Infirmary on Thursday, the 10th of May, 1855. Patient stated that some time in September last he was engaged in making a stack of corn, and "whilst heading it," in an effort to catch one of the sheaves which a man on the ground was pitching to him, he suddenly bent his body back, at the same time turning the upper part of it nearly half round; at the moment he felt something give way in his left groin, and on examination discovered a small hard swelling about the size of a hazel nut in this situation. This at first was attended with scarcely any tenderness or pain, and only occasionally, when it became a little larger and more tender, did it give him any annoyance. He says, that though he could at times move it a little about, yet it never altogether disappeared, but he does not recollect whether it was affected by coughing or other muscular efforts. The tumour remained in this condition until the Saturday before admission, on which day, whilst engaged at labouring work, he found it to enlarge and to become exquisitely painful. With difficulty he got home, when, by the advice of the neighbours, he had hot stupes, poultices, &c., applied to it. On Tuesday he observed it again to become suddenly larger, more tender, and soft. Along with these symptoms he was affected with pain about the umbilicus of a "colicky nature," and soon after he observed the tumour to increase and become soft; swelling and tenderness of the belly occurred; he had no vomiting, and his bowels were several times opened by salts, which he took a couple of days before.

State on Admission.—Occupying the left groin is an oblong swelling, about the size of a goose-egg, and having somewhat the appearance of a bubo; it has a dusky brown appearance around the base, but about the size of a crown piece on the most prominent part of it presents a leadenish hue; it is quite soft and fluctuating, whilst the entire of the abdomen, as high as the navel, and the scrotum of the left side, are affected with œdematous erysipelas. His countenance is sunken and anxious-looking; skin hot and dry; tongue covered with a white fur; pulse, 100, feeble; urine scanty; no vomiting; bowels freed this morning. He complains of violent pain in the abdomen, and great tenderness in and around the swelling. He was immediately put to bed and ordered two grains of opium, the latter to be repeated every second hour till sleep was procured; to have arrowroot, beef tea, and wine.

11th. Got two pills before he went to sleep, then slept for four hours; he took some of the beef tea and wine, and says the sleep has refreshed him very much. The pain in the belly is better, but the soreness in and around the tumour not diminished. On removing the poultice, the slough gave way at its upper part, and from a minute opening, a thinnish brown serum, and air of a most fœtid character, issued. The erysipelatous appearance of the abdomen is increased, and the countenance has the same haggard, anxious look as on yesterday; tongue furred, skin hot and dry, pulse quick and weak, bowels not opened since yesterday. A bistoury was now introduced into the aperture, and the tumour completely laid open. A large quantity of brownish-looking serum, mixed with liquid fæces, flowed out, whilst air of a most fœtid character issued from the wound with a hissing noise. A fermenting poultice was now desired to be applied, and repeated every four hours. Solution of chloride of lime to be sprinkled round the bed, and bark and ammonia were directed to be given every fourth hour; an anodyne at night, and to continue the arrow root, &c., as yesterday. In the evening he said he felt much better. A good deal of discharge, similar to that of the morning, had come away each time the poultices were changed, and the pain and tenderness of the belly soon much diminished.

12th. Bowels once opened; motion thin and watery; he feels and appears much the same as yesterday. On removing the poultice, a large, white, and shreddy slough was seen to occupy the fold of the groin, from the centre of which the discharge (unaltered in character) continued to flow. The swelling of the abdomen and scrotum much diminished, the other symptoms remain unaltered since last visit. As the slough appeared to prevent a free exit for the discharge, it was, to a large extent, carefully removed with scissors and dressing forceps, and along with it a hard lump of fæces the size of a marble. There was left behind, parallel with, but for the most part above, Poupart's ligament, an irregular, ill-looking ulcer, about three inches long, and one and a-half wide, surrounded with jagged and sloughing edges. This was washed out by means of a syringe, with a dilute solution of chloride of lime. Same treatment to be continued.

14th. Much better; the removal of the slough, by giving free issue to the discharge, has given the patient much relief. He has slept well at night since, and his countenance is improved in appearance; tongue still coated, pulse 92, and weak; his bowels have been freed three times, all the motions were thin and fœtid, and the last was observed to have some pus mixed with it. The swelling and tenderness of the abdomen and scrotum are nearly gone, and the ulcer appears healthier, the slough having come away altogether from its inferior part. The cavity is now filled with pus of a character similar to that passed by stool.

20th. Patient continues to improve in appearance, and sleeps well. The slough has now completely come away, leaving a deep and irregular ulcer behind, discharging a large quantity of fœtid pus (which he also passes with each stool). From the depth and jagged appearance of the ulcer, a correct view of the parts cannot be obtained, but the pus appears to proceed from the internal abdominal ring; the slough has involved the interior boundary of the inguinal canal, leaving the cord partially exposed in the most inferior portion of the sore. The surface of the ulcer around the edges is covered with pale and flabby granulations, partially overlapping its irregular and jagged edges; his tongue is cleaning round the margin; pulse 90, stronger; appetite good; bowels regular; stools still contain pus. Poultice to be discontinued, the edges of the ulcer and granulations to be touched with caustic, and dry lint, with a thick compress and bandage, to be applied. He is to continue the bark mixture, &c., and to have boiled mutton.

25th. Getting better, each day feels stronger, sleeps well and eats heartily. The discharge from the ulcer is diminished, and much less offensive; pale and flabby granulations cover its surface, and are on a level with the surrounding skin, but the edges are still sharp and undermined. Tongue cleaner, skin natural, pulse 82; bowels regular; stools now contain scarcely any pus. To continue treatment as before.

From this date the patient steadily improved, the ulcer gradually closed, its healing having been retarded by the intractable disposition of the edges; the pus after a little time ceased to appear in the stools, and the patient left the hospital on the 22nd of June, having regained his accustomed health.

Observations.—In this case there are many points of interest to the practical surgeon, not the least of which are its great rarity and favourable termination. From the history which the man gave me of its occurrence and subsequent course, and from the sudden manner with which the erysipelas supervened upon the equally sudden softening of the tumour, as also from the position of the latter, and peculiar appearance of the countenance—notwithstanding the absence of vomiting and constipation—I considered the case as one of strangulated inguinal hernia, and this diagnosis was fully verified by its progress subsequent to admission. The absence of vomiting and constipation may be accounted for by the peculiar nature and position of the strangulation, which I believe to have consisted of a small portion of the sigmoid flexure of the colon, *involving very little of its calibre;* the distance, therefore, intervening between it and the stomach rendered this organ less prone to sympathise with the local affection, and the non-complete occlusion of the bowel made constipation less likely to ensue; besides, the length of time which the protrusion had remained unreduced had accustomed the parts to their unnatural position, and tended, when strangulation did occur, to prevent those symptoms so characteristic of it. The favourable termination of the case was owing, I think, to the very small portion of gut involved (the size of the neck of the sac being in proportion), and the completeness of the strangulation, which must have further diminished the latter, but chiefly to the pervious condition of the bowel, which permitted its free and natural evacuation, and prevented the accumulation of fæces in the neighbourhood of, and their discharge, for any lengthened period, through the orifice existing between the bowel and abdominal parietes; the margin of this opening, therefore, being unirritated, in a short time yielded to pressure and the application of nitrate of silver; and fæcal fistula, which in such cases usually lasts for life, was but of brief duration, the treatment adopted proving effectual in closing the abnormal opening.

Case of Uterine Hæmorrhage before Delivery.

By GABRIEL STOKES, M.D., Mullingar.

Mary Daly, aged 35, a butcher's wife, a strong, vigorous woman, in the eighth month of her twelfth pregnancy, was attacked with uterine hæmorrhage, recurring several times each day. This state of things continued for about a fortnight, and reduced her very much when her labour came on, each pain being accompanied by violent hæmorrhage.

She had no attendance but an old midwife, and it appears, after labour had continued for fourteen hours in this way, that the placenta was completely expelled from the vagina and the flooding ceased. The midwife separated the placenta, and although the woman was in a state of extreme exhaustion, strong labour pains continued. Twenty-four hours subsequent to this, and thirty-eight from the commencement of her labour, I first saw her, and was informed of the foregoing circumstances, and shown the placenta.

The woman, though blanched by loss of blood and prostrated in the extreme, still had pains; and on making an examination I found an arm presentation, the hand being in the vagina. I immediately introduced my hand, and succeeded in turning and delivering without much difficulty, giving stimulants freely.

She continued for several hours in a very low and faint condition; but reaction slowly setting in, she gradually recovered without having any bad symptom.

This case appears to me to be one of placental presentation, and is remarkable from the circumstance of the placenta having been expelled by the contractile power of the uterus *previous to the birth of the child*, and I have no doubt the child would also have been born (of course dead) by the natural efforts of the uterus, were it not for the accidental circumstance of the arm presentation.

In cases of placental presentation, I have more than once seen the hæmorrhage controlled by the pressure of the descending head of the child, and the woman safely delivered without any operative interference; but I am not aware of any case on record where the placenta was actually expelled before the birth of the child by the natural contraction of the uterus, thus putting a stop to the hæmorrhage, although the birth of the child was retarded by an arm presentation; and when delivery was effected by turning the child, that the patient recovered after such violent and long-continued flooding.

Hospital Reports.

STEEVENS' HOSPITAL.

The following are amongst some of the operations recently performed in this hospital by Mr. Colles:—

Operation for Synblepharon.

This affection was produced by lime getting into the left eye, and as the result of the burn thus inflicted, the lids became adherent to the ball of the eye, and to one another. The adhesions had been three times divided, but without success. A broad belt of integument could be seen to extend from one lid to the other, and adhering to the front of the cornea, so as to cover one-half of the pupil. This band allowed the lids to be partially opened, but prevented the motions of the eyeball; a small opening existed at the inner angle of the eye, where the band was deficient.

Operation.—A narrow knife was passed beneath the bridge of skin, which was then freely separated from the eyeball. The band was then divided across the centre, the flap being turned over to the inner side of the lid, and retained there by suture, in order to prevent fresh adhesions. A thin, smooth piece of lead was then passed between the lids and the ball of the eye, the presence of which caused little or no inconvenience. A short time only has elapsed since the operation, but the case can be said to be progressing most favourably.

Cancer of the Tongue removed by Ligature.

The patient was a female, æt. 40. The disease had existed for about twelve months. The disease presented an excavated ulcer, with hard, prominent edges; lancinating pains and profuse salivation were present. The disease was confined to the right side of the tongue; it had not encroached on the mesial line.

From the extent of the disease, three ligatures were required; a needle, armed with a long ligature, was first passed in the mesial line, at the posterior edge of the ulcer; the further end of the same ligature, previously doubled, was then passed anterior to the disease, but still in the centre. When divided, three ligatures were formed, which were all tied very tightly, so as to circumscribe the diseased part. Four days afterwards, they had to be again tightened, and in eight days the portion ligatured came away. A small, hard tubercle, which remained on the posterior edge of the wound, was tied with a single thread, and on this coming away, which it did in four days, a healthy, granulating surface remained.

The patient left the hospital before the ulcer was completely healed, so we are unable to speak with any certainty of the result. Cancer of the tongue is notoriously apt to recur, and such may be the result in this instance; but, as excision is attended with more or less violent bleeding, it is satisfactory to know that even a large amount of disease may be included in a ligature, and its separation effected without the risk of hæmorrhage.

Removal of Tumour of the Neck.

The patient was a man, æt. 45. The tumour, which had existed for twelve months, was situated beneath the left ear, which was displaced upwards, and extended forwards over the ramus of the jaw; it was of an oval form, and somewhat larger than a walnut. The integuments were ulcerated over the centre, and around the ulcer were adherent to the tumour itself; from the ulcer there was constantly a thin, watery discharge, which irritated the surrounding parts. Though of comparatively small size, the deep-seated connexions of the tumour were intimate and extensive. It was included in two elliptical incisions, and removed, with the exception of one small process, which dipped very deeply behind and below the ear; to this the actual cautery was applied; no bad consequences ensued, and the case is doing remarkably well.

RICHMOND HOSPITAL.

Operation for Ectropeon—Plastic Method.

This operation was performed by Dr. Hutton, to remedy the deformity of complete eversion of the left lower eyelid, the result of the cicatrization of a strumous ulcer in a remarkably good-looking girl, eighteen years of age. The operation was commenced by making a semilunar incision, extending from within the internal to the level of the external commissure of the eyelid, about a quarter of an inch below the cicatrix, then dissecting the flap as far up as the tarsal cartilage, so as to free the lid completely from all abnormal adhesions. A V-shaped portion was then taken out of the lid, and the edges accurately brought together by interrupted suture. The eyelid was thus completely restored to its former position. Some folds of conjunctiva which bulged unnaturally were removed with scissors.—It now remained to fill up the space left by the detachment of the lid and its restoration to its original position. This was effected by taking a piece of integument from the malar region, the exact size of which was regulated by applying over the skin to be removed a portion of leather previously adapted to the part to be supplied. The flap was then turned into its new position The isthmus by which its vital connexion was maintained, and which lay immediately beneath the external canthus, required, of course, to be a little more than one-fourth round. The flap, which fitted very accurately, was secured by three or four points of suture. The patient was kept under the influence of chloroform during the entire time of the operation, which of necessity, occupied a good deal of time.

The wounds all healed favourably, and, as the result of this well-planned proceeding, a very conspicuous deformity has been completely remedied.

HOSPITAL, SCUTARI.

Communicated by A. B. Brabazon, *Civil Medical Staff.*

Although the correspondent of a medical journal may regret the absence of anything new or striking in the substance of his communications, yet both he and his readers must feel sincere pleasure when the fact of the absence of such material indicates the comparative immunity from disease of an immense army in camp, under a trying climate; and of the excellent sanitary condition of an hospital which at one period obtained such unenviable notoriety as that at Scutari. But while I cannot deem any individual case of sufficient interest to warrant me in occupying the pages of the Gazette, yet as many of its readers may hope soon to have an opportunity of affording professional service to the army in the East, I think that a short general review of the diseases which have been under treatment for the last three months may, to them at least, not be uninteresting. I have also, through the kindness of some of my professional brethren here, military and civil, been enabled to collect a few cases of gunshot wounds, in brief detail, which present some peculiarities as to their nature and consequences. The medical cases which have been admitted into hospital since my duties here commenced, have been, in order of frequency, diarrhœa, dysentery, fever (remittent, intermittent, and continued), and some cases of jaundice, arising either from exposure to the heat of the sun, or in connexion with hepatic affections contracted in tropical climates. Diarrhœa appears either as bilious diarrhœa, or simple passive serous diarrhœa, arising from a relaxed condition of the mucous membrane. I may here remark, that in this climate there is an extraordinary tendency to relaxation of the whole tract of mucous membrane, at least the gastro-pulmonary portion; even in the conjunctiva, passive congestion of the vessels is frequently seen. These forms of diarrhœa, if taken in time, are not dangerous; but there is a form of diarrhœa in which, with copious liquid feculent stools, there is blood passed in large quantities, at first unattended by pain or fever, and this form, which is, I think, really a premonitory stage of dysentery, if allowed to go on unchecked for a very few days, will invariably end in decided dysentery. This is in fact the only stage of dysentery which I have found benefited by acetate of lead and opium. Acute dysentery is comparatively rarely met with here, owing to the fact that the primary attacks usually take place in the Crimea, and are first treated in the hospitals there, consequently the disease is met with here either in a sub-acute or chronic form; these are the cases which are most difficult in their treatment, and most fatal in their results. In fact, once ulceration is established, I really think they are almost hopeless, although the tenacity of life is wonderful. These cases, as far as I can gather from the imperfect accounts given by patients, usually commence with the form of diarrhœa mentioned above, which goes on for some days, and then the decided symptoms of dysentery make their appearance. I really believe a fair trial has been given to every kind of treatment here. Nit. argent. by the mouth and by injection, and sulphate of copper, appear to have failed completely in most cases in which they were tried. The sulphuric acid treatment, combined and uncombined with tinct. opii, does not deserve greater credit. My friend, Mr. Hall, C.M.S., states that he has found 20 minim doses of balsam copaiba of decided benefit, and

Mr. Knight, C.M.S., states that he has found morphia in solution, in small doses frequently repeated, very successful. I am inclined to agree with those who had the benefit of the sad experience of the past winter, in thinking that the exhibition of Grey powder and Dover's powder, with occasional doses of castor oil and tinct. opii, deserves the most credit in these unmanageable cases, giving occasionally opiate enemata to relieve the pain and tenesmus, and adhering to farinaceous diet, not omitting counter-irritation, which is absolutely necessary. In the *post mortem* examinations made during the past winter, the ulceration was generally found confined to the colon, not extending beyond the sigmoid flexure.

There appears to be a close connexion between remittent fever and dysentery. I have seldom seen one without the other. This, of course, renders the treatment of the remittent more difficult. Our remittent fever is very obstinate and a very dangerous form of disease; it is constantly recurrent, and if it last beyond a certain time, is very likely to become typhus or typhoid. Quinine, in moderate doses, appears to me to be the best treatment; wine must be administered cautiously, for if given in too large quantities, it is very apt to increase the tendency to abdominal complications. Continued fever is comparatively very rare here as a primary disease. I have only seen three or four cases of maculated fever since I arrived here; this is, I think, mainly owing to the present excellent condition of the hospital, as, during the over-crowded state of the hospital last winter, it was of frequent occurrence. In the few cases which I have seen, there was head affection very early, extreme prostration, and copious sweating; in one case under my own treatment, typhoid pneumonia occurred, and the patient sank from uncontrollable diarrhœa. The *post mortem* examination revealed, besides the affection of the lungs, an enlarged spleen, with granular deposit, granular disease of the kidneys, inflammation at the lower part of the small intestine, with enlargement of Peyer's glands. This man had previously suffered from remittent fever. The intermittent fever is generally quotidian, and is not attended by any marked peculiarities, either as to progress or treatment. The close approach to complete convalescence is most remarkable after any of these affections, probably owing to peculiarity of climate. I question much whether patients ever completely arrive at their original state of health while they remain here, after an attack of fever or dysentery. Relapses, also, are very frequent; fortunately, however, changes to a more bracing air than that afforded by the enervating, soft, oriental climate, rapidly set them up.

I will now, in conclusion, add notes of a few cases of gunshot wounds. They were taken down as briefly as possible by the surgeons in attendance, whose time was too fully occupied to admit of making more lengthened observations.

Case I.—*Reported by Staff Assistant-Surgeon* D. Campbell Taylor.

Corporal David Lovett, 63rd Regiment, admitted into hospital November 27, 1854, for gunshot wound of the head, received at Inkermann, while kneeling, in the act of discharging his rifle; the ball struck his head over left parietal bone, close to sagittal suture, and split; one half appeared to have entered the cranium, while the other passed between the scalp and cranium to the occiput, whence it was extracted. Patient was insensible for two days after receipt of injury, and on admission into hospital was still hemiplegic on the right side; his mental faculties were not affected; he returned rational answers to questions put to him, and complained of no pain. Pupils were dilated; pulse 100. Ordered purgatives; cold water dressing to wound; spoon diet.

December 2nd.—Slight power of flexing fore-arm, but no power of grasping anything in the hand. Right leg still powerless; pupils dilated. Ordered alterative doses of blue pill.

December 13th.—Two pieces of bone were extracted this morning, one of which was marked with lead; the pulsations of the brain can be plainly seen through the opening in cranium. Blue pill and water dressing continued.

December 29th.—Patient has now some command over right leg, being able to flex it when lying on his back; wound doing well. Continuantur medicamenta.

January 15th, 1855.—Since last report, there has been marked improvement. Patient can sit up in bed, and feed and wash himself; wound healing.

February 24th.—Patient has now perfect use of his right arm, but the right leg is still weak; he cannot put it firmly on the ground, and he drags it after him in walking; wound healed. Invalided to England.

Case II.—*Reported by Assistant Surgeon* Holton, *2nd Queen's Royals.*

A Russian soldier was struck by a musket-ball, which shattered the bones of the right leg, a little below the knee. About a month after the receipt of the injury, it was found necessary to remove the limb, which was done by a circular operation about the junction of the lower and middle third. Secondary hæmorrhage occurred on the eighth day after the operation, from the inner angle of the cicatrix. Compression was applied over the trunk of the femoral artery; cold applied to the stump; this checked the hæmorrhage at the time, but it recurred several times to a greater or less amount during the following week; the patient was consequently reduced to a very low state, and it was deemed expedient to cut down and tie the bleeding vessel. This was performed by Dr. Holton, by laying open the cicatrix for about three inches on the face of the stump. On separating the edges of the wound, a clot, about the size of a large egg, was found, and the hæmorrhage evidently proceeded from the main artery, which appeared healthy. The clot was turned out, and a ligature applied to the bleeding mouth of the artery. Notwithstanding the low state to which he was reduced, his pulse being scarcely perceptible, under the judicious use of stimulants he rallied, and the stump healed without any return of the bleeding.

CASE III.—*Reported by Staff Assistant-Surgeon* D. CAMPBELL TAYLOR.

Henry White, admitted into hospital June 26th, 1855, with a gun-shot wound of the left groin, received in action on the 18th. The ball entered a little below Poupart's ligament, external to the pubis, passed downwards, backwards, and outwards, through internal femoral and gluteal region, and escaped posteriorly. On admission there was profuse discharge from the wound, and numbness along the inside of the thigh, but the limb can be used without difficulty. July 4th. Aperture of entrance much smaller, discharge less in quantity, and healthy. On the evening of the 1st instant there was slight hæmorrhage. 8th. Wound improving fast; no return of the hæmorrhage. 15th. A piece of cloth was extracted yesterday from the anterior aperture. Still in hospital, but doing well.

CASE IV.—*Reported by Staff Assistant-Surgeon* HINDE.

Serjeant George Anderson, 34th Regiment, æt. 27, was wounded on 18th June in the left arm and leg. The ball entered the arm at about the junction of the middle with the lower third, passed backwards and inwards, and came out about three inches above the elbow joint. He lay on the field from four in the morning until six o'clock in the evening, when he was conveyed direct on board ship, where he remained for two days. On his passage down to Scutari, hæmorrhage took place from the wound in the arm. A tourniquet was immediately applied, which controlled the bleeding. When admitted into the Barrack Hospital, on the morning of the 24th, under the care of Mr. Best, Civil Medical Staff, he appeared very low and weak, and looked as if he had lost a considerable quantity of blood. He complained of great pain, which was accounted for by the swelling and œdema of the arm, supposed to be probably occasioned by the necessary pressure of the tourniquet. After he had been in the ward some time, pressure was cautiously and gradually diminished, and no blood appeared. About four o'clock on the morning of the 25th, hæmorrhage, to about the amount of 1½ oz., took place, and the tourniquet was again tightened. About eleven o'clock, as he complained of excessive pain, the instrument was made slack. He then appeared very easy, and slept until about three o'clock. While Mr. Hinde was in the ward, he called out that it was bleeding again. It was stopped by pressure in four or five minutes, but not before he had lost fully 1½ pint of blood. This made him very faint. His face was blanched, and his pulse imperceptible at the wrist. He was a little revived by the use of stimulants, which he could only take in very small quantities at a time, owing to the excessive irritability of his stomach. As there was now no doubt that the brachial artery was wounded, Mr. Best determined upon at once applying a ligature to that vessel at the seat of injury. Accordingly, he cut down on the vessel in the course of the wound, discovered the opening in the artery, and applied ligatures above and below the opening. There was not 1 oz. of blood lost during the operation, and the edges of the wound were brought together in the usual manner. He never made the slightest attempt at a rally, and died about an hour after the operation was performed.

An examination was made of the injured arm, and it was found that the median and internal cutaneous nerves had been divided by the ball. The two venæ comites were also completely divided. The biceps muscle was torn, and there was a considerable amount of effusion of blood into the limb; the brachial artery had been wounded about one inch and a-half above its bifurcation; the ligatures had been applied properly above and below the wound in the artery.

Remarks.—Case No. I. is, I think, interesting, as showing the possibility of a ball splitting; an ignorance of this fact might and has misled surgeons. It is also interesting as showing the possibility of recovery, from such serious consequences as must result from the lodgment of a foreign body, such as a bullet, in or upon the brain, supposing the symptoms detailed to have resulted from this cause; no doubt the symptoms might have been those of compression, caused by the pieces of bone which were extracted; but there is every reason to believe that a portion of the bullet is somewhere within the cranium. Mr. Guthrie appears to think, that persons rarely recover with a ball lodged in the anterior lobes of the brain, and cites cases, in which the patient having apparently perfectly recovered from the effects of such an injury, died afterwards suddenly: it would be interesting to watch this case.

CASE II. involves a point of practice, as to whether, in such cases, the course to be adopted should be ligature of the artery high up, or cutting down upon the face of the stump and tying the vessel there. First Class Staff Surgeon, Delmege, who has had considerable experience in gunshot wounds, informs me, that in those cases in which the femoral artery has been tied in Scarpa's angle, in cases of secondary hæmorrhage from the stump after amputation of the thigh, sloughing of the stump has frequently occurred from the supply of blood by anastamoses being cut off.

Case III. is only an instance of the manner in which arteries appear to be pushed aside by a ball; otherwise, in this case, how did the intervening circumflex artery or the large anastomosing branches of the circumflex and sciatic arteries at the back of the thigh escape.

In Case IV., even if the patient had lived, the limb could scarcely have been saved, judging from the amount of injury done to the veins and nerves. Gangrene would most probably set in. In such cases, where hæmorrhage recurs more than once, and that there is a suspicion of the main artery being the injured vessel, I believe the safest practice would be to cut down upon it at once, and tie it at the seat of injury.

Reviews.

Reflections on Petit's Operation and on Purgatives after Herniotomy. By Joseph Sampson Gamgee, Assistant Surgeon to the Royal Free Hospital.

In this memoir, we are presented with some excellent and practical remarks upon two points of the utmost importance in connexion with strangulated hernia, viz., the propriety of endeavouring to remove the stricture without opening the sac, and of giving purgatives after the stricture has been relieved. The history of Petit's operation is an interesting addition to surgical literature. We learn that the extra-peritoneal division of the stricture was originally introduced in the early part of the last century by Jean Louis Petit,* but that it did not gain much repute until 1788, when Monro strenuously defended it after having put it to the test of even wider experience than had been done by its originator. In 1833, Mr. Aston Key strongly advocated the operation in a special memoir. Mr. Luke and Mr. N. Ward have also contributed much to revive this operation and to bring it into general use; whilst the dissentients, we are told, are unimportant in point of numbers, but their character renders them formidable; amongst them are Mr. Syme, Mr. Hancock, and Mr. Prescott Hewett. As holding a middle place, and recommending the operation in particular cases only, as where the hernial tumour is very large, we may mention the names of Cooper, Boyer, Lawrence. Mr. Liston, who was opposed to the operation in 1840, strenuously advises it in 1846. Mr. Gamgee finally states, that "opposed on the grounds of preconceived opinions, it has steadily gained in repute, in proportion as it has been put to the test of experience." Mr. Hancock is very decidedly opposed to the operation, and has written, we are told, forcibly and ably in support of his own opinion. His pamphlet is especially criticized by our author, who shows that several distinguished authorities, stated by Mr. Hancock to be opponents of Petit's operation, are in reality favourable to it—as, for example, Sir A. Cooper, who, as has been already stated, recommends it in certain cases, and Richter, mentioned by Mr. Hancock as "an able opponent of Petit's operation," but who is really "one of its most elaborate and weighty advocates."

Statistics, it is also stated, are in favour of the extra-peritoneal section of the stricture, though the numbers are obviously too small to enable the profession to form any positive decision on the subject. Mr. Luke (Med. Chir. Trans., vol. xxxi. p. 103) operated on fifty-nine cases by Petit's method; seven died: and on twenty-five, by opening the sac; of these latter eight died. Mr. Ward was less successful; he gives sixty-nine operations with twenty-one deaths. On the other hand, at St. George's Hospital, "where the sac is all but universally opened," nineteen deaths occurred in 75 operations. Uniting Mr. Luke's and Mr. Ward's results (Petit's Operation), we have 153 cases and thirty-six deaths, whilst the opposite line of practice at St. George's gives seventy-five cases and nineteen deaths.

In conclusion, Mr. Gamgee observes, "If this experience do not amount to demonstrative proof that by the performance of Petit's operation in appropriate cases the fatality of strangulated hernia may be greatly lessened, it is certainly quite sufficient not only to encourage, but to demand further investigations, in order that we may arrive at a correct knowledge of the cases in which one or the other operation is peculiarly applicable."

The second part of the memoir is occupied with an inquiry into the propriety of giving purgatives soon after the operation of herniotomy. The difficulty of the subject is enhanced when the opinions of distinguished surgical writers are consulted, for we find "one line of practice insisted on by Louis, Cooper, Hey, Lawrence, Richter, Velpeau, and Syme, and a totally opposite one by Dupuytren, Liston, Miller, Hancock, and others."

Mr. Hancock brings statistics to prove that purgatives after the operation do harm, in opposition to the high authority of Mr. Lawrence, who, after a practice of nearly half a century in one of the largest hospitals in London; "insisted on the propriety of opening the bowels early after the operation, and characterized as entirely groundless the reasons adduced against that practice." The arguments for and against this practice are very fairly canvassed; and after observing that in order to determine finally on the merits of the question, a more extensive and accurate experience is required, than is, perhaps, recorded in the note books of any individual surgeon, Mr. Gamgee gives the following practical rules as the result of his own experience and observation:—

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* Described in the *Traité des Opérations de Chirurgie*, by René J. C. Garengeot, Paris, tome i. p. 211.

"1. When the condition of the gut is good, and there is little or no peritonitis, an oleaginous enema should be given an hour or two after the operation, and repeated after three or four hours in case of failure, or a mild purgative exhibited by the mouth.

"2. When the peritoneal inflammation is intense, antiphlogistics must be perseveringly employed, and though a simple enema may be given in the first six hours, it is unadvisable to excite the action of the bowels until the next day, either by more active enemata or purgatives by the mouth.

"3. In the case of mortification threatening the gut, the bowels should be kept quiet by opium; and purgatives as well as enemata jealously abstained from, until the danger of perforation has passed."

Whilst believing that these rules promise to be "faithful guides for practice," Mr. Gamgee says, "the great rule is to observe rigorously the symptoms of each particular case." We also fully agree with him in the concluding paragraph. "If there be any class of cases in medicine and surgery (and there are many) in which systems are injurious, and in which each case requires to be studied of itself with the light of reason and experience, that class is pre-eminently the one which comprises cases of strangulated hernia."

SELECTIONS FROM BRITISH AND FOREIGN JOURNALS, &c.

Case of Femoral Hernia, containing the Caput Cæcum, and complicated with an Irregular Obturator Artery surrounding and constricting the Protrusion. By J. Spence, F.R.C.S., Edinburgh.

[We continue, from page 208, Dr. Spence's observations on the very interesting case of Femoral Hernia, which we copied from the July number of the *Edinburgh Medical Journal.*]

Remarks.—This case is, I believe, unique in one respect, being, as far as I can learn, the only one in which the presence of the artery has been ascertained during the operation, and avoided in incising the ordinary seat of constriction, whilst its ligature and division were ultimately necessitated, from the vessel itself being the obstacle to reduction.

But I think it principally worthy of being detailed, as it seems to me to show practically that, in cases of femoral hernia, where the irregular vessel exists, its presence may be ascertained, and the constricting portion of the crural ring may be sufficiently divided to admit of reduction, without wounding the irregular vessel, if certain precautions be adopted; and secondly, when complications may necessitate or endanger its division, it shows that the vessel may be tied, and what the plan of procedure in such cases ought to be.

First, then, as to the risk and chance of avoiding injury in ordinary cases of femoral hernia.

I will not enter into anatomical details further than to say, that there are three different positions in which we find the obturator artery placed in relation to the femoral ring, when it arises by a common trunk with the epigastric, viz.—1st. Descending closely applied upon the external iliac vein, to reach the obturator foramen, and hence lying to the outside of, or behind and to the outside of a femoral hernia, and therefore out of all risk of injury during the operation. 2nd. Passing down from the epigastric towards the obturator foramen, further removed from the vein, so as to divide the femoral ring into two sections, in which case it might be either pushed aside, or stretched in front of a hernial protrusion, or, as in a case described by the late Mr. Allan Burns, have two small hernial protrusions, one on either side of it. 3rd. The artery arising from the epigastric passes upwards, then curves round the upper, and descends along the inner margin of the femoral ring to gain the obturator foramen, so as to encircle a hernia passing out at the femoral opening, in all the directions available for incision. It is to this last irregularity I would at present direct attention. As regards the statistics of this form of irregularity, there is considerable discrepancy, some authorities, as Mr. Quain, stating it at nearly 1 in 10; Velpeau, 1 in 15; and Monro, 1 in 20 or 25. It is evident, however, that practically, no matter how rare or frequent such an irregularity may be, the surgeon can never predicate in what case he may meet with it, and is therefore bound to act in every case with the same caution as if it might be present.

This arterial irregularity, as coincident with a femoral hernia, must be, of course, still more rare; yet, there are several such cases on record.

There is a preparation in the Barclayan department of the Museum of the Edinburgh College of Surgeons, showing such a coincidence; and the late Mr. Liston had one in his museum.

In at least two cases the artery has been wounded during the operation for strangulated femoral hernia: once in a case operated on by

Baron Dupuytren, where its division was only discovered after the patient's death from other causes. The other case occurred to Mr. Skey of St. Bartholomew's; in it the bleeding was profuse at the time, the lower end of the artery was tied, the upper could not be secured, but bleeding was arrested by other means, for the patient only died some days afterwards, from the effects of a drastic purgative, given by mistake. Lastly, in a case which occurred to the late Dr. Richard Mackenzie, it was found, on the patient's death some weeks after the operation, that the irregular obturator had encircled the neck of the sac, but had escaped division.

Now, these cases show both that the artery has been accidentally cut, and accidentally avoided; but the case I have recorded goes a step further, for it shows that the surgeon, by proceeding cautiously, and feeling with the pulp of his finger, before dividing the constriction formed by the deeper or higher portion of the crural arch, may detect the presence of the irregular vessel, and then, by cautiously notching the constriction, to a very slight extent, at two points of its circumference, he will gain room sufficient to enable him, either with his nail or the point of a small flat director, to push the artery out of the way, while he divides the stricture more fully.

By following this plan, I was enabled to relieve the constriction, so far as to draw down and examine the intestines contained in the sac, and readily to reduce the portion of the ileum, so that, under ordinary circumstances, no further incision would have been necessary, and the vessel would have remained intact.

Of course, if the operator holds the opinion that the whole thickness of the crural arch, including Poupart's ligament, ought to be divided in every case, then the irregular vessel runs a much greater risk, than if he limits his incision to the division of that portion of the arch formed by the convergence of the abdominal fasciæ, below Poupart's ligament, which immediately constricts the sac, and which is all that I have almost ever found it necessary to divide in cases of femoral hernia.

Secondly. The case, however, shows that certain complications, occurring in a femoral hernia where the irregular obturator artery was present, might render it necessary to divide the surrounding textures so freely, for the purpose of reducing the protrusion, that there would be very great risk of wounding the vessel; or that, from the artery tightly surrounding the protrusion, it might absolutely require to be divided, as itself an obstacle to reduction. And this leads us to the consideration of what these complications are, and how such difficulties may be best met and overcome.

Though I have mentioned the irregularity of the obturator artery as being an obvious and serious complication of the case, it was by no means that which gave rise to the greatest difficulty;—indeed, from my remarks under the first head, it may be seen that I hold that, except for the other conditions of the hernia, the irregular vessel would not have given rise to much difficulty, or been in much danger of being wounded.

The real difficulties which complicated the operation were, I think, the bulky and irregular form of the protruded cœcum; its comparatively fixed position, by its peritoneal attachments, near the site of the femoral opening; and its posterior cellular connexions, not allowing it to slip back like portions of the floating intestine; and last, not least, the state of the bowel from the previous attempts at the taxis, forbidding all further pressure or manipulation that could possibly be avoided.

The form and connexions of the cœcum always render its reduction slow and gradual, even under more favourable circumstances, where the bowel can safely bear moderate compression, and where the constricting textures have been very freely divided, as I found in a case of inguinal cœcal hernia, on which I operated some months ago, where there was no limitation to making the incision of the constriction very free indeed; and I have also seen the same difficulty, though to a much less degree, in cases where the sigmoid flexure of the colon formed the contents of inguinal hernia. In femoral hernia, however, where our incisions must, in general, be much more limited, and, especially, when we have ascertained the presence of an irregular artery round the upper part of the ring, the causes of difficulty I have alluded to become very embarrassing, and require us to adopt great caution in dividing the constricting textures; indeed, it was the eccentric pressure of the bulky distended gut which brought it into contact with structures which do not ordinarily form the seat of stricture, and in this way the irregular artery, dragged and stretched to the utmost by the distended portion of the cœcum, had come to form a cord-like constriction upon it, requiring division before the bowel could be returned.

As to the plan to be adopted in such cases of femoral hernia, requiring such free incisions to relieve the bowel, I can only say that, after much consideration of this case, I would still proceed to divide the superimposed textures by the same method, viz., by dissecting cautiously through the lower division of the tendon of the external oblique, and the other textures, down to the peritoneum, in a line corresponding to the centre of the femoral ring, the chord being drawn aside. Thus all danger of wounding the artery accidentally is avoided, and if it be found itself constricting the swelling, it will not be found very difficult to bring it into view and put ligatures upon it.

Indeed, this plan is that which Sir Astley

Cooper recommended as safest and best in all cases of large femoral hernia; and although I cannot think, after some experience in femoral herniæ, that it is either necessary or advisable as a general plan, it will be found the safest in complicated cases requiring more than usually extensive incisions; it is, in fact, a cautious dissection down upon the upper part of the sac, or the parietal peritoneum immediately above, and continuous with it, and if carefully conducted, attended neither with difficulty nor danger.

[On this case being read before the Medico-Chirurgical Society of Edinburgh, Dr. John Struthers said]:—

He had always looked carefully to the position of the abnormal obturator artery; and, out of several hundred subjects examined, he could not recollect one in which the artery was so placed that it would unmistakeably have surrounded the neck of a femoral hernia. It might, however, be so placed more frequently, perhaps in one in a hundred cases. Practically, it was enough to know that it occurred occasionally, and as, in ordinary circumstances, it is absolutely impossible to ascertain its presence or absence before dividing the stricture, the precautions must be taken alike in all cases. The peculiarities of Mr. Spence's interesting case required a much larger division than usual. Before he had ascertained the existence of the artery, he (Mr. Spence) had already divided as much as is usually sufficient to allow of the return of the hernia, as the finger could be introduced. Hence he was able to feel for the artery; and requiring a larger incision, which would in unskilful hands have sacrificed the artery, he cut down upon it and secured it, and his having succeeded in doing so reflected the greatest credit on him both as anatomist and surgeon. In ordinary circumstances, however, the surgeon had no means of knowing whether the artery was present or not. Blunting the edge of the knife might be a good enough precaution, but the great practical rule would still be to make as limited a division of the stricture as possible, and a very small one is usually enough. If, in doing so, the artery should be divided, no blame should be attached to the surgeon, even were he to fail in an attempt to secure the vessel. The artery might be there and not be divided, as was well shown by the case alluded to by Mr. Spence, and which occurred to his lamented colleague, Dr. Mackenzie, who was just about to publish it last year when he left us for the seat of war. The patient died from some other cause before the wound had healed; and, on dissection, the abnormal obturator artery and vein were found to occupy the dangerous position, but had not been injured. Dr. Mackenzie had shown him the preparation; and both were surprised how the artery had escaped, as it lay so near. He (Dr. Struthers) was glad to have this opportunity of making the case known.

Nor would the division of this artery be necessarily fatal. A larger artery, the deep epigastric, had been found to have been divided in the operation for inguinal hernia, without any hæmorrhage following. This, however, as far as is known, had occurred only once, and there were several instances in which its division in that operation proved fatal, and several in which a similar result followed the operation of paracentesis, when not done in the middle line; and a few cases also, one related by S. Cooper, and several quoted by Mr. Spence to-night, in which division of the abnormal obturator in the operation for femoral hernia proved fatal. We must not, therefore, make too light of this much-talked-of danger. Even if the operation were performed with care, it was quite possible that the artery might be divided; and then it might be impossible to secure it. Mr. Spence, however, had shown that when a large incision was required, the existence of the artery might be ascertained, and the danger overcome by doing as he did.

Mr. Spence stated that Dr. Struthers had misunderstood what he had said in reading the history of the case. He had merely divided the lower margin of the falciform process, and it was whilst trying to get the nail of his finger below the deeper constriction to guide the knife in dividing the stricture, that he felt the irregular vessel pulsating, and consequently, before any hernia, however small, could have been reduced. It was from thus ascertaining the presence of the artery, that he took the precaution of dividing the crural ring to only a very slight extent, at two different points of its circumference, so as to gain room to introduce the point of the finger still further to push the vessel upwards. And it was the precaution of careful examination, and limited division of the arch, in the first instance, which he wished to inculcate as one important deduction from the case.

Dr. Struthers said that his remarks regarding the impracticability of ascertaining the existence of the artery were intended to apply to the ordinary circumstances of the operation.

Treatment of Anæmia in Children. By Professor L. W. VON MAUTHNER of Vienna.

The treatment of the anæmic conditions of children is frequently one of the most difficult problems for the practical physician. The therapeutic agents from which to select are not numerous, and when the object is to operate with rapidity against the blood impoverishment, there is not one upon which we can rely, as they all act slowly, and are difficult of assimilation. Another great source of difficulty is found in the fact, that while anæmic children are more liable than others to local hyperæmia and severe forms of inflammation, the phenomena of reaction are more varied and often most abnormal. Even in children of good constitution, who are attacked with inflammatory diseases, cases will occur in which it is necessary to contend against anæmia. The recognition of this state is of the utmost importance, as children cannot so long endure an impoverished condition of the blood as adults.

Much tact and experience are required to hit the boundary line accurately, when the inflammatory irritation is already so far subdued that the transition can with safety be made to a nutritious and tonic treatment. Notwithstanding all the laudable efforts which have been made to render medicine complete, and to base it upon fixed principles, it is impossible, on this point, to lay down a certain rule, because medicine, like painting, is an art, and ever must remain one.

It must be looked upon as an unfavourable sign when children, in the early period of severe inflammatory affections, especially of pneumonia, become anæmic.

Against the anæmia of the new-born we possess, in the milk of a strong, healthy nurse, a truly universal remedy. It is lamentable how many thousand children are lost because they are deprived of it.

There is no form of anæmia among the new-born in which the nurse's milk is not useful. This is easy of explanation when we consider, as Hervieux has proved, that anæmia is very frequent among the new-born, not only as a sequence of other affections, but also as a substantive disease. The restoration of the normal blood-mass may be obtained, as it were, by magic, through a suitable nurse, and thus the evil be eradicated.

It may be laid down as a rule that the physician must always direct that a child should have a nurse, and not be weaned before the end of the first year in all cases in which the parents are persons of infirm health. When the anæmia of the new-born is occasioned by syphilis, which so often happens, nothing more can be done so long as the disease is latent.

Great attention must be paid to the skin in anæmic children. Flannel should be worn in winter, and in other seasons raw, uncoloured silk. In children who become anæmic during dentition, nourishment, air, and attention to the skin are the chief points. Above all things, children at the breast should not be weaned. The nurse should be well nourished, and should get wine, if she has been accustomed to it and bears it well. Artificially reared children should have good unskimmed milk, diluted with water, as drink, and should also get broth and panada, with eggs.

Anæmic children, during dentition, are often attacked with various moist chronic eruptions, especially eczema. The ordinary treatment by cold applications, or the douche, which answers so well with adults and strong children, in such cases augments the evil. Covering the affected parts with wool, or silk wadding, operates beneficially. To parts such as the head and face, to which this is inapplicable, the following ointment is useful:—

℞. Cetacei, dr. vi.
Ceræ alb. dr. ij.
Mercur. præcip. rubr. gr. x.
Ol. olivar. unc. unam et semis.
M. Ft. unguent. leni calore.

The internal use of the extract of walnut leaves, in combination with rhubarb, acts better in these cases than cod liver oil, which is often with difficulty tolerated, and which destroys the appetite. The following formula is employed:—

℞. Extr. fol. jugland. alcoh. dr. i.
Tinct. rhei aquos. unc. i. M.

Necroscopic examinations prove that no organ suffers so much, or at so early a period, in anæmic children, as the liver. Anæmic children have been known to chew rhubarb root as it were by instinct. If cod liver oil is considered advisable, and the stomach will not bear it plain, or that it is passed from the bowels unchanged, it may be administered thus:—

℞. Ol. jecoris aselli,
Mucil. gum. Arab.
Syr. cort. aurant. āā. unc. semis.
Aq. flor. tiliæ, unc. unam.

Intermittent fever is not only frequently followed by anæmia, but anæmic children become the subjects of paroxysms of intermittent fever. These fits point out, for the most part, the development of tubercles in consequence of the anæmia; nevertheless, a fatal termination may be warded off by the use of quinine, and the removal of the child to the country.

Observing upon the anæmia of growing children, and at the period of the second dentition, Dr. von Mauthner observes:—"How often do we hear the following narrative of disease! A boy of nine years of age, who is very industrious and ambitious, and works during school hours, and also at home, grows very rapidly, becomes emaciated, pale, and irritable. He also is affected with wandering pains, shiverings, weariness, loss of appetite, longing after certain kinds of food, cough, palpitations, and constipation of the bowels. This state of things lasts for months—the child not being well and still not absolutely sick.

Mental repose and removal to the country, with the internal use of some preparation of iron, restore the boy to health, but if these means be neglected, then the case goes on to the development of tubercles. It is not easy to explain the *modus operandi* of iron in anæmic states, but experience loudly proclaims its power. The soluble salts of iron are more efficacious than other preparations, Tinct. Ferri Mur., Citrat. Ferri et Quinæ, Tinct. Malatis Ferri, Lactas Ferri, &c., &c., are adapted to children.

Dr. von Mauthner has for some years been in the habit of administering the blood of the ox, and the iron in this form, in combination with a group of organic materials, is found to be easy of assimilation. The examination of the bodies of children, who have taken the blood for weeks, proves that very little of it has been found in the intestines. Children take it willingly, particularly when the extractum sanguinis bovini is pulverised and mixed with sugar.

Dr. von M. gives a formula for lozenges:—

℞ Sanguinis bovini, gr. iij.
Cioccoladæ, gr. vi.

M. secundum artem cum mucil. tragacanth. et ft. trochisc.

In many instances, as much as a drachm of the extractum sanguinis bovini has been administered to anæmic children in the day, with the best results.—*Journal für Kinderkrankheiten.*

Treatment of Pneumonia in Children without bloodletting.

Dr. H. A. Abelin, of Stockholm, treats the different forms of pneumonia without having recourse to bloodletting, general or local; his treatment being more expectant than active. When mercury is employed, it is always the mild preparation, Hyd. c. Creta, which is found to be most suitable; antimonials and turpentine are also given. Dr. A. says he has no reason to regret having adopted this mild treatment; on the contrary, he thinks there are good grounds for giving it a preference at the early period of life, judging from the experience acquired in the institution over which he presides. Drs. Huss and Malmsten, have for many years pursued this mode of practice in the pneumonia of adult life, with the best results. Bleeding is only admissible in the first stage, or that of congestion; when the disease has passed into the stage of hepatization, it is held to be positively injurious. This mode of proceeding meets the approbation of other Swedish physicians, who specially commend the use of turpentine in the advanced stages of pneumonia, as it aids the expectoration and supports the powers of life.—*Journal für Kinderkrankheiten.*

Cases in which Electricity has been successfully applied.

M. Demarguay recounts the following cases:—

Obs. 1.—A young man came to M. Demarguay, to have the right submaxillary gland removed by operation; it was the size of a hen's egg; a variety of means had been used, but without success; for its reduction, and his physician thought there was nothing for it but extirpation. Before having recourse to this, M. Demarguay determined to try galvanic puncture. The tumour was pierced by four needles, and a current established through them by means of the apparatus of Bretin. The operation was attended with a little pain. The third time it was done the size of the tumour was sensibly diminished; at the eighth time it was only the size of a small pigeon's egg; now, after twelve applications, a month after the first, the gland is of its normal size.

Obs. 2.—M. K. fell from his horse, upon the point of his shoulder. A surgeon who was called found a luxation, and immediately reduced it. Some days after, M. K. found he could make no use of his arm; the shoulder looked deformed, the acromion and the head of the bone appearing, as it were, too plainly; in fact, the deltoid was paralyzed, and so atrophied that the osseous parts appeared as if but covered by the skin. M. Demarguay had recourse to galvano-magnetism. The second application was followed by such results that a cure was confidently anticipated; in fine, fifteen days afterwards, at the ninth application, the movements of the arm were almost entirely restored.

Obs. 3, 4, and 5.—Three patients with disease of the genito-urinary apparatus, two of them old men, septogenarians, were affected with retention of urine, without either stricture of the urethra, or engorgement or hypertrophy of the prostate; their bladders, being of large capacity, had almost lost their power of contraction, and could expel but a small quantity of their contents. The third was a young man affected with spermatorrhea and entire loss of erections. In one of the old men, who seemed remarkably sensitive to electricity, there was a very decided improvement after the first application; the urine was voided in a jet, and almost entirely. After the third time, the patient completely emptied his bladder; there only remained some catarrh, against which proper measures were directed. Electrization, however, was continued until the cure was complete. In the other, who was of more advanced age, and a constitution more deteriorated, and of much more obtuse sensibility, eight trials restored to the bladder its lost power; but this patient afterwards died of diarrhœa. The third patient presented an aggravated form of spermatorrhea. Nux vomica, belladonna, cold douche and sulphur baths had all been tried in vain. Galvano-puncture, combined with general treatment, was employed; after eight applications he was almost cured.—*Gazette des Hôpitaux.*

DUBLIN: PUBLISHED BY W. B. KELLY,
8, GRAFTON-STREET.
LONDON: S. HIGHLEY, 32, FLEET-STREET.
EDINBURGH: MACLACHLAN & STEWART.
August 15, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.
SENT FREE BY POST.
Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 15.—Vol. II. SEPTEMBER 1, 1855. Price 5d.

Cryptogamic Vegetations on the Mucous Coat of the Stomach after Death.

BY DR. LEES,

PHYSICIAN TO THE MEATH HOSPITAL.

A man sixty years of age, a literary character, and having led a solitary life for several years, died after a very short illness. Three months after his burial, circumstances occurred which led to a suspicion of his death having been caused by poison; an inquest was accordingly directed, and the body was disinterred for the purpose of a medico-legal examination.

The mucous surface of the stomach was of a deep chocolate colour, and on it were scattered numerous white circular bodies, elevated at the edge and depressed in the centre; some of these were very minute, and had the appearance of a white powder sprinkled on the membrane. From the nature of the soil in which the body had been interred being of a peculiarly dry calcareous stratum, and capable, to a great extent, of arresting the progress of decomposition in this as well as in two other bodies placed in the same grave, I at first supposed that these substances might have been calcareous depositions, but analysis proved they were not; and as they did not appear to be composed of animal matter, I therefore concluded they were of vegetable origin, in fact, parasite plants, epiphytes, entophytes, similar to those which Gruby, Rokitansky, Bennett, and others have shown to affect the common integuments and mucous membrane. These parasites are microscopic growths belonging to the lowest class of the vegetable kingdom (fungi), and are mostly found on diseased surfaces, so that it is probable that the diseased tissue affords a suitable nidus for their development, though some have thought that they were the cause of the diseased state. They are found upon and within the common integument in tinea favosa, in sycosis, in porrigo decalvans, in plica polonica, in pityriasis versicolor, and according to Rokitansky, "the mould formations upon sloughing ulcers, and in senile gangrene, come also under this head." They are often found upon the mucous membrane of the mouth, the pharynx, the œsophagus, the larynx, and the intestinal canal in apthous, croupy, and diptheritic exudations. Amongst these fungi may be also included those found in cancrum oris, in the sputa and lungs in a case of pneumothorax, as also in the black sordes of the teeth in typhous patients; and on the typhus-ulcers of the intestines, Rokitansky states, that these fungi resemble those of favus: "the thallus-threads are, however, mostly much longer, more slender, and have frequently, at their free extremity, protuberances replete with minute granules (spores)." I consider the case which came under my observation as highly interesting and important in a medico-legal point of view, for although similar appearances have been noticed by authors, yet none of them have alluded to the possibility of their being of vegetable origin; thus, both Orfila and Christison mention similar cases which have been mistaken for deposits of arsenic, but which were found to be composed of animal matter.

The peculiar deposits on this stomach, I am satisfied (both from the results of analysis and the microscopical examination), were of a vegetable nature, to be classed among the parasitical cryptogamia, and tend to confirm the opinion that internal parasites are not exclusively derived from the animal kingdom, but that there are entophytes as well as entozoa. Since I brought this case under the notice of the Pathological Society (now some years ago), a case, presenting some resemblance to it, has been published by Mr. Blagden, in the Provincial Medical and Surgical Journal.

A body having been disinterred eighteen months after death, on suspicion of the individual having been poisoned with arsenic, Mr. B. says: "I found the mucous membrane of the stomach, as Dr. Lees described it in his case, of a deep chocolate colour; at the cardiac extremity it was studded with numerous white granular bodies, about the size of millet seeds; there were none at the pyloric extremity, nor in any other part of the alimentary canal." The stomach and intestines were examined by Mr. Leethby, of the London Hospital, who could not detect any traces of arsenic, but considered that these bodies were composed of adipocire. The growth of cryptogamic vegetables upon *living* animals has been placed beyond doubt by the researches of Audoin and Bassi, on the disease of silk-worms, called Muscardine, and which these naturalists have shown to be attributable to the metamorphosis of the fatty tissue of the insect into the radicle or thallus of a new cryptogamic plant, which Audoin has named Botrytis Bassiana. In the Annals of Natural History (vol. viii.) there are two well authenticated cases of similar plants having been found in the lungs of birds. The first case is by Deslongchamps, of a domesticated Eider-duck, which died after suffering from great dyspnœa for near a month: he found the air-cells lined by large patches of mould. And the other case was that of a Flamingo, in which Owen found tubercular cavities, and the smaller bronchial ramifications were lined with a green vegetable mould or mucor.

In a communication made to the Royal Academy of Sciences, at Berlin, in 1842, by the celebrated physiologist Müller, on the development of fungi in the lungs of birds, he says, that "*the vegetable nature of the disease is not to be doubted.*" And in the Edinburgh Medical and Surgical Journal (No. 151), a case is related by Mr. Goodsir, Curator to the College of Surgeons, of a man, nineteen years of age, who ejected from his stomach every morning, without any effort of vomiting, an acid fluid containing vegetable organisms.

Dislocation of the Head of the Femur into the Thyroid Foramen.

BY GABRIEL STOKES, M.D., Mullingar.

John Hawkins, ætat. 35, a labourer, strong and muscular, while carrying a heavy sack of corn, slipped on a wet flag, and fell with his legs widely separated, the sack falling heavily on his right hip. On attempting to get up he found his leg was perfectly powerless, and every attempt on his part to move it productive of violent pain. He was removed to his own home, and within half an hour of the occurrence of the accident I saw him, in conjunction with Surgeon Dillon Kelly.

On stripping him, and lifting him to the standing position, the nature of the injury was evident. The trunk was bent, forming nearly a right angle with the extremities, and any attempt to erect the body caused great pain. The toes and knees were everted, and the axis of the femur formed an obtuse retreating angle with the axis of the trunk.

Posteriorly, the right nates were flattened, the folds nearly obliterated, and the trochanteric prominence replaced by an irregular concavity.

Anteriorly, the upper part of the right thigh appeared flattened and broader than the left, while interiorly the adductive muscles were found rigid and tense, and the head of the femur could be distinctly felt beneath the ramus of the pubis. The right lower extremity measured fully two inches longer than the left, and adduction of that limb was quite impossible.

The patient being placed on his left side on the floor, a soft cotton sheet, folded diagonally, was passed over the perineum and brought across the left shoulder; two silk handkerchiefs were applied to the ankle with the close hitch, and another soft sheet was placed round the upper part of the thigh, tied together at the end, so as to form a large loop, through which Mr. Kelly passed his head and shoulders, in order that by making lateral traction, the head of the femur might be drawn out of the thyroid foramen.

Extension and counter-extension were now made by two strong men, whilst Mr. Kelly, by the means before alluded to, steadily endeavoured to raise the head of the bone from its dislocated position. This was continued for a few minutes, when I suddenly adducted the limb, and the head of the femur slipped into the acetebulum *with so exceedingly slight a snap*, that it was only perceptible to Mr. Kelly. Finding, however, that adduction was effected, we relaxed the extension, and discovered that the dislocation was perfectly reduced, and the motions of the limb completely restored.

This case I think worth being recorded, inasmuch as it bears out the case, and corroborates the opinion published by Mr. Colles in a late number of the GAZETTE, viz., that in certain dislocations of the hip joint, the return of the head of the femur into the acetabulum, on the reduction of the dislocation, is not accompanied with the loud snap audible to all persons present which is generally described. In this case the snap was so slight that it was only perceptible to Mr. Kelly, who at the moment grasped the thigh, nor did it convey to his mind that the dislocation was reduced, a fact that he was not satisfied of till we relaxed the extension and examined the limb. At this time we had not seen Mr. Colles's case in the GAZETTE. The reason of the loud snap being so generally set down as a sign of the reduction in dislocation of the hip, I think, arises from the fact that the most frequent form of dislocation is upwards on the dorsum of the ilium; and I am inclined to expect that future observations will show that it is in this form alone that the loud snap on reduction occurs.

This case, also, bears out the observations of Professor Ferguson, in his *System of Practical Surgery*, where he says: "Extension can scarcely be deemed requisite in effecting reduction in this case. I am inclined, however, to recommend a slight degree of it, as the patient's body can thus be kept more steady. Transverse force must then be applied in the manner above described, and in all likelihood the parts will be speedily adjusted, far less energy being seemingly required in this case than in others." For in this case, giving all due weight to the fact that the reduction was effected within half-an-hour of the accident, yet the extension and counter-extension were comparatively trifling.

SKIN DISEASES.

From the French of M. Maurice Chausit.

BY T. K. BARTON A.B., M.B., T.C.D., &c.

(*Continued from page* 187.)

Impetigo.—Definition.—" Impetigo is an inflammation of the skin, characterized by small confluent, superficial, flattened pustules, distended by a purulent fluid, which, when dry, forms soft, thick, irregular crusts, disposed as if in stages on the surface of the skin by a secretion more or less abundant, which gives rise to new crusts without the appearance of new pustules, and by brownish stains which remain a long time."

M. Chausit, having described impetigo *acute* and *chronic*, considers separately *impetigo sparsa* and *figurata*, *impetigo larvalis*, and *impetigo of the scalp*. Of these, the varieties named *sparsa* and *figurata* demand no special notice, inasmuch as they differ in no essential point from the other forms, having received these names merely from the first being arranged in scattered patches, and the second in tolerably defined figures. Omitting these, then, we will follow M. Chausit through the other phases of this malady.

Acute Impetigo.

" Sometimes the development of acute impetigo is announced by severe general disturbance of the system; in other cases there is little or no precursory fever. Whether severe or mild, this lasts from one to two days before the local phenomena present themselves. The parts which are about to be affected acquire a feeling of tension and heat, and are soon covered with red isolated spots, at first but slightly prominent—sometimes accompanied by a sensation of acute lancinating pain. These spots change into pustules, of which the largest do not exceed the size of a millet-seed, and which are completely formed in from thirty-six to forty-eight hours. These pustules may remain separate, but frequently they become confluent, and thus give rise to considerable purulent collections; when these burst, a honey-like viscous fluid escapes, which concretes and forms crusts, at first of a yellowish tint, and with a certain degree of transparency like amber or the tears of gum which run from certain trees. The crusts may remain separate, but most frequently they join, become compounded together, and form rough unequal masses, which by degrees get a deeper colour, resembling dry honey. These crusts are always superficial, as if disposed upon the surfaces of the skin, soft and gummy; when, however, they have arrived at a considerable development, they crack at their driest part, and permit an ichorous fluid to escape; if they begin to fall before the disease is at all modified, they expose to view a red, soft, secreting surface, which constantly pours out a purulent fluid forming new crusts, which conduct themselves exactly as their predecessors, and so on, while any trace of inflammation remains. As the inflammation gives way the crusts diminish in thickness, the secretion becomes less abundant, the redness of the diseased surfaces diminishes, until merely a brown stain remains, which persists for some time. In this way the disease frequently terminates in two or three weeks; but sometimes the inflammation, when disappearing in one place, attacks a fresh surface, thus indefinitely prolonging the disease.

Chronic Impetigo.

Chronic impetigo presents itself under two different forms: either it is caused by successive eruptions of acute impetigo, in which case it differs in nothing but its indefinite existence from the acute form; or it is caused by an incessant secretion, unaccompanied by any acute symptoms whatever; in this form pustules are not seldom to be found here and there; at the confines of the diseased skin they are sometimes seen, but the disease really consists in a purulent secretion which the skin constantly pours forth, and which constantly augments the thick crusts which cover the diseased surface; these irregular crusts become dry at their outer part, remaining soft and moist internally; when they repose on the skin they are easily detached, but soon re-form and gain a considerable size. In old or cachectic persons impetigo frequently attacks the inferior extremities, and continuing indefinitely it encases the limb in a thick, greenish, rough crust, like the bark of a tree, to which it has been frequently compared. When this cracks of itself, or is broken, a purulent ichorous fluid escapes from the interstices, exhaling a disagreeable—sometimes fetid odour. This form, to which Willan has given the name of *Impetigo Scabida,* is often complicated with œdema, or ulceration of an atonic kind; it may cause the alteration or fall of the nails; its duration is quite indefinite.

Impetigo Larvalis.

This form, peculiar to infancy, has characters so entirely its own, as to claim justly to be considered as a distinct variety. It is characterized by pustules which are never so purely purulent as those of impetigo, nor yet bear any resemblance to the sero-purulent vesicles of eczema impetigenodes. These pustules, to which the name of *achores* has been given, are small, superficial, of a yellowish-white colour, united in groups—sometimes confluent, they give rise to the formation of yellow or greenish crusts, which are sometimes thin, soft, and laminated, at other times thick, unequal, and yellow. The achores present the peculiar characteristic of being very easily followed by ulceration; sometimes very extended and persistent, but always superficial. Impetigo larvalis occupies by preference the scalp, the ears, and chiefly the face, which it covers entirely as a mask in severe cases.

The precise age at which impetigo larvalis appears, affects its appearance; according as it occurs nearer to birth it has less of an impetigenous character. In infants, at the most, it not unfrequently appears in the scalp, and as the incessant formation of yellow crusts is the striking symptom, it has been named *crustea lactea.* In general, impetigo larvalis comes out without any appreciable precursory symptoms, by little pustules in groups, sometimes confluent, of a yellowish white colour, accompanied by an itching, which compels the child to scratch the part, and thus often the pustules are broken. A yellowish transparent glutinous liquid escapes, which forms soft crusts, either isolated or dispersed in patches, according as the disease is discrete or confluent. The crusts are continually augmented by a sticky fluid, which continues to be secreted without the formation of new pustules; and it sometimes happens from want of cleanliness, that a great part of the face and almost the whole scalp of the child appears one mass of scab.

The eruption, very often commencing at the posterior part of the scalp, extends in front to the temples, and from thence spreads over the whole face. When the pustules are somewhat larger than these on the scalp, but are accompanied by an intense itching, the crusts which they give rise to are thin and yellow, sometimes greenish, which, when extended over the whole visage, covers it like a mask. Tormented by the incessant itching, the little patients scratch and tear themselves, so that the face is scattered over with thick, dry, black crusts, formed by coagulated blood, which gives a peculiar physiognomy to the disease, which Alibert has graphically described, in saying that it resembled a cake covered with burnt sugar. Impetigo larvalis but rarely attacks the nose or eyelids; if it has any seat of predilection it is certainly the ears, but the pustules are larger than on the face, the crusts are thick and large, painful excoriations and fissures too occur in this situation.

Impetigo larvalis is sometimes complicated with engorgement and abscess of the lymphatic ganglions which will require to be opened. Although, when it occurs in the face, it is often complicated with cracks and excoriations which bleed freely, yet there is no reason to dread any cicatrix afterwards, for this eruption never gives rise to anything of the kind.

Impetigo of the Scalp

Is characterized by yellowish, prominent pustules, followed by crusts, offering this particular, that they are divided into unequal parts by granulations, which, scattered here and there through the hair, give a special character to this variety. The disease is announced by a little heat and sometimes itching in the part where the eruption is about to appear; soon little scattered pustules, without any areola of inflammation, appear, and the eruption is complete in three or four days. The pustules, when they burst give issue to a purulent fluid of a pale yellow colour, but thick and viscid, which concretes very rapidly and forms crusts, which in some cases correspond to groups of confluent pustules, matting together a number of hairs; or, more frequently, they correspond to isolated pustules, and are always traversed by a hair. The crusts, after some time, become very dry, hard, and friable. When they break up, their debris resembles the dust of old mortar, or the dry plaster that falls from old walls.

When it has existed for a long time, impetigo of the scalp exhales a disagreeable odour, like rancid butter, and gives rise to lice in large numbers. The disease occupies almost exclusively the posterior and superior parts of the head; and it is remarked that although often so inveterate and disgusting a malady, it is never followed by baldness, the hair always springs up afresh when the disease is cured.

Causes of Impetigo.—In general, impetigo is developed under the influence of a white, soft lymphatic temperament, but, as we have already remarked, its form is modified by individual circumstances, especially according to the age of the patient. In infancy it presents itself always under the form of *achores;* from this, should the constitution remain lymphatic, it becomes modified as age advances, until it presents its complete state in the adult.

It is most frequent in individuals of a fine delicate skin—young persons and women; it is encouraged by whatever circumstances tend to produce a predominance of the white fluids, as lactation in women. It becomes rare as we approach the decline of life; when it does appear in old men it is brought on by the enfeebling effects of age and privations.

Acute impetigo appears to be most frequent in springtime, in those of sanguine temperament, and generally comes on after violent exercise or excess of some sort. Chronic impetigo is essentially connected with the lymphatic temperament. Impetigo larvalis (achores) is produced and kept up by the predominance of a white temperament, it affects the fattest, purest infants. It is often under the excitement of dentition that it appears in some disorder of the digestive organs; too long a time at the breast predisposes to it, and sometimes it depends on the state of the nurse, and ceases when the milk is changed. Impetigo of the scalp is most frequently produced by want of cleanliness; it affects young persons who wear their hair very long, and are not very careful as to whether it is clean or not. Impetigo is never contagious.

Passing over M. Chausit's observations on the diagnosis and prognosis of this disease, we conclude with a sketch of the treatment he recommends.

Treatment.—When the disease is acute, simple tepid baths are very useful. Acidulated drinks are sometimes enough internally, at other times purgatives are to be employed locally. Emollient lotions, such as decoction of poppies, almond emulsion, or tepid milk; sometimes local bleedings are useful. The chronic form of impetigo demands more vigorous measures: purgatives of calomel, magnesia, aloes or castor oil locally; vapour baths and douches, which clean and rouse the vitality of the diseased skin. Sulphur is administered empirically, but with decided good effect; the best way of giving it is to prescribe hot baths and drinking of some of the sulphur waters. M. Cazenave has obtained good effects from the employment of baths of sea water in case of rebellious chronic impetigo. Ointments, in general, are of no use in the treatment of impetigo. Cauterization, except the use of weak solution of nitrate of silver, we never advise.

Remembering that this disease is almost necessarily united to a peculiar constitution, all rational treatment will be devoted to modify and improve this. With this object the hydrochlorate of lime is a useful agent united with cod-liver oil.

When all other means have failed we sometimes gain an unhoped-for cure by the employment of arsenic.

In impetigo larvalis the general health is good, and it requires hardly any treatment. Internally we advise some gentle laxative, such as some of the preparations of magnesia; after this, sulphur administered with caution. Generally we abstain from ointments, which only add to the irritation; or poultices, which macerate the skin and give rise to excoriations; to calm the itching, we powder the part with dry starch, afterwards we advise the child to be washed with tepid milk or water.

In impetigo of the scalp, the hair must be cut close and the head well cleaned. Then emollient or alcaline lotions, simple or alcaline baths, sulphurous lotions or douches, with strict cleanliness, suffices to obtain a cure.

Hospital Reports.

RICHMOND SURGICAL HOSPITAL.

Perinæal Sectio in Stricture.

Mr. Fleming proposed Professor Syme's operation in a remarkably obstinate and almost impermeable case of stricture. He followed, as accurately as it was possible, Mr. Syme's directions, and used the special instruments he recommended. The subject of the case was a man, aged about thirty years. He was a porter by trade, and was of most irregular habits. Three years back, Mr. Fleming had punctured his bladder above the pubis for retention of urine, supervening on impassable stricture. The man left hospital perfectly recovered from the operation, and with a urethra which admitted freely No. 6 to No. 8 catheters, all the prominent symptoms of stricture having disappeared. It was yet remarked, whilst under treatment, that there was a persistent disposition to contraction in the stricture, and that the slightest interruption in the use of instruments caused the most rapid tightness, and that whilst No. 6 would pass freely to day, to-morrow a difficulty would be experienced in the introduction of No. 2, or No. 3, or even No. 1. Mr. Syme's operation was proposed at this time, but would not be acceded to. The man, on his discharge from hospital, was put upon his guard as to the result of neglect. He renewed his habits, perhaps necessarily identified with the irregular hours of his business. On many occasions, in the intervening two years, Dr. Fleming was applied to by him for relief from retention of urine during his numerous fits of intoxication. The greatest difficulty attended the introduction of the smallest sized instruments. He yet clung to his place, and at last was forced to seek hospital relief, his symptoms became so intense. On admission, the most aggravated symptoms of urinary and vesical irritation were present. It is unnecessary here to recapitulate them. At first, no instrument could by possibility be directed into the bladder, the urine escaped "*guttatim.*" Its physical and chemical characters being most morbid, rigors, with their sequelæ, supervened on each attempt at catheterism, no matter what precaution was adopted. At last, Mr. Syme's original grooved staffs of the smallest size were introduced, and subsequently his improved catheters-staff entered the bladder, and at this special time an opportunity was taken to perform his operation. The details shall be cited and reported on a future occasion. At present favourable results can be calculated upon in one of the most unpromising and unmanageable cases it is possible to contemplate. Complications exist in it which render it not one to test fairly Mr. Syme's suggestion. It is perhaps, however, the more important on that account, as it may tend to establish the fact of comparative impunity in carrying out his views. The stricture in this case was at or about the bulb, and the case is now progressing tolerably well.

Cancer of the Lip.

Mr. Fleming operated in two cases of labial cancer, which presented some features of interest. The one was a female, and the disease occupied the lower lip; the other was a male, in whom the disease occupied the unusual situation of the upper lip. In the case of the female, it appeared that the patient was between 40 and 50 years of age, and that she was married. She gave the ordinary account of cancer, which commenced in the central portion of the lower lip; to it a quack in the country had applied a caustic plaister, and as the result, a considerable angular portion had been destroyed, having a hardened knot in each angle, at the red border. The woman had not been a smoker. The result of the operation was satisfactory. The contraction of the lip was very considerable, and the traction equally so; but at the end of a fortnight, the woman left hospital, and the breadth had much decreased, having a very comely lip.

The subject of cancer in the upper lip was a man, æt. 60. For two years, he had been under observation with an ulcer engaging the red border and corresponding central portion of the upper lip. No treatment adopted produced any satisfactory effect. The extent of the ulcer was about one inch in breadth, by half in depth, and a deep tuck remained in the portion which had partially cicatrized. The hardness was very considerable. Mr. Fleming removed the diseased portion by angular section with a scissors, and nothing could be more satisfactory than the result. The wound healed by the adhesive process.

TO THE EDITORS OF THE DUBLIN HOSPITAL GAZETTE.

3, *Wellington Place, Belfast.*

Doctor M'Cormac presents his compliments to the Conductors of the DUBLIN HOSPITAL GAZETTE, and requests the favour of the insertion of the following reclamation:—

"I would lay claim to the discovery of the formation of tubercle mainly from the carbon and other impurities retained in the blood, owing to the imperfect performance of the function of respiration. This I assume to demonstrate in my treatise on the Nature, Treatment, and Prevention of Tubercle, presently to be published.

"HENRY M'CORMAC, M.D.

"*August* 25, 1855."

Reviews.

Mittheilungen aus der Pfeufr'schen Klinik.—Epidemische Cholera. Von PROFESSOR DR. BUHL. (*Zeitschrift für Rationelle Medicin,* 1855.)

Numerous as the communications on the subject of cholera are, and eminent and zealous as the contributors to our knowledge of the disease have been, we must, nevertheless, admit that there is still much to be learned, and many points upon which we would gladly seek for information. Impressed with the truth of the foregoing statement, Professor Buhl (on the occasion of the recent epidemic visitation of cholera at Munich) proposed to himself certain questions for scientific investigation, more especially connected with the pathology of this most mysterious malady.

Ample materials were provided for the prosecution of the inquiries, inasmuch as three hundred and four cases of cholera were under Dr. Buhl's observation in the hospital during two months. In Munich, as in most other situations, the cholera presented itself with preliminary diarrhœa, which continued from half a day to three days. In some cases it was prolonged to eight days, and in some rare examples from two to three weeks. In seven-tenths of the cases of cholera, the access took place in the night (most frequently after midnight); three-tenths were between noon and evening. In general the vomiting followed the diarrhœa: the vomited matter consisted at first of undigested food, afterwards of the ordinary fluid. The reaction of the fluid vomited was at first acid, but soon became neutral, or even alkaline.

The cholera-diarrhœa was distinguished from the premonitory diarrhœa, by the rapidity with which the dejections (three to six) followed each other, but more particularly by the intensity of the accompanying symptoms, and the peculiar character of the evacuations. Dr. Buhl has found crystals of the ammoniaco-magnesian phosphate in great abundance in the recently passed fluid; and he has also seen fungi in considerable quantity, especially in the pellicle, which forms on the surface when it has been permitted to stand for some time; vibriones are more rare. Dr. Buhl describes, with much minuteness, the symptoms of cholera, with which we are so familiar. He makes some interesting observations on the temperature in cholera, which are calculated to remove the generally received impression.

We must premise, that in his examinations he employed the centigrade thermometer. He says: "Synchronously with the access of collapse and cyanosis, the temperature falls. Physicians speak in the same exaggerated style of icy-coldness, as they do of glowing heat in fever; the latter only exceeds the normal temperature by two degrees, and the former only falls below it by the like amount. The investigations which I have made on this point exhibit a much higher temperature than was hitherto supposed to exist. I employed from half an hour to an hour on each examination, with a view of obviating erroneous results, as the thermometer rises with extreme slowness. The average temperature in the axilla was 35.5—36° C., only 1.5—2° below the normal standard."

"Cyanosis and diminution of temperature coincide, the parts of the skin which are most blue are also coldest, and where the cyanosis does not exist, or has disappeared, the temperature is highest."

In rapidly fatal cases the skin is moist and clammy, like a frog's skin. Hammerynk perceived a urinous odour to be emitted by the skin. The general sensibility is diminished, but here and there one meets with hyperæsthesia.

In his observations on the state of the muscles in cholera, Professor Buhl alludes to the condition of the iris. He says it is subjected, in a moderate degree, to the spasmodic influence. The pupil is thereby contracted. As to the heart, he says, the impulse is weak to the last degree, or not to be felt. From the assertion of authors that only one of the heart's sounds is audible he positively dissents. (According to Canstatt the diastolic sound alone is audible, while, on the contrary, Günsburg, Reinhardt and Leubuscher state that only the systolic sound can be heard.)

Numerous investigations have convinced the author that in by far the greater number of cases (nine-tenths) both sounds are equally distinct.

Connected with this part of the subject, we may refer to a case, the *post-mortem* appearances of which were exhibited at a meeting of the Pathological Society of this city by Dr. Stokes. The case was one of malignant cholera, in which, a few hours after collapse had been established, a loud bellows murmur was discovered at the upper and middle sternal region. The murmur was audible up to the period of the young man's death. No disease of the muscular tissue or valves of the heart was found on dissection, but a large coagulum existed in the left ventricle and extended up into the aorta. Dr. Stokes was of opinion that the bellows murmur was of recent origin, and that it was caused by the interference of this remarkable coagulum with the action of the aortic valves. As far as we know, this phenomenon had not been observed previously. Professor Buhl says, that the diastolic sound often resembles a short blowing sound; once he heard a distinct but feeble pericardial attrition murmur. In two cases there was a loud systolic murmur, but it was caused by valvular insufficiency of long standing.

The average frequency of the pulse was—in men from 80 to 100, in women from 90 to 120. When the pulse can no longer be felt at the radial, it is generally perceptible in the carotid or crural artery.

The most severe cases proved fatal in from twelve to twenty-four hours—seldom in less than twelve. The minimum was five hours. The maximum may be stated at thirty-six; after this period the symptoms were more or less changed, so as no longer to admit of the disease being termed an attack of cholera.

The strange phenomena, already noticed by Doyère, Heinrick, and others, were also present in many cases observed by Dr. Buhl, namely, the elevation of the temperature in the axilla (from thirty-five to thirty-seven) at the approach of death, as also the violent contractions of the muscles of the extremities, of the abdomen, and even the masticatory muscles, and seminal emission also frequently occurred. Of the 304 cases of cholera treated, eighty died—thirty-seven males and forty-three females. The chemical results obtained in the investigations instituted by Dr. Buhl are of the highest interest, and for these he is indebted to Dr. Voit, who, we are informed, is a young physician of considerable eminence in this department of science.

An attentive perusal of the pathological and chemical portion of Dr. Buhl's treatise would amply confirm the opinion we have arrived at, namely, that he has largely contributed to the amount of knowledge hitherto possessed upon this subject. We regret that our limits do not admit of our giving more space to a notice of his valuable communication.

On the Uses of the Pancreas, as illustrated by Pathology. By Dr. Eisenmann. (*Vierteljahrschrift fur die Praktische Heilkunde.*)

The beautiful experiments of Claude Bernard on the uses of the pancreatic fluid, induced the author to see whether the results obtained by the French physiologist might contribute to the further diagnosis of diseases of the pancreas.

Bernard's theory is, that the office of the pancreatic fluid is that of "emulsifying or saponifying the neutral fatty matters contained in the food, by decomposing them into glycerine and their respective fatty acids, and so rendering them absorbable."*

If this be really the use of the pancreas, it is to be inferred that when its functions are destroyed by disease, fatty matters should appear in the digestives. "It was interesting," says Dr. Eisenmann, "to observe how observations at the bed-side confirmed the 'provisions' of science." The details of six cases of disease of the pancreas, one of which was under the author's own observation, are given.

The six cases proved fatal. In all abundant fatty dejections had been observed, and in all there was found induration, or other morbid changes, in the pancreas. The principal symptoms observed were, copious flow of saliva, sense of weight in the epigastrium, which pressure did not increase, flatulence, diminished temperature of the body, a small and slow pulse. There was constipation; but the fæces contained a peculiar yellowish substance, like congealed fat, and which was really fatty matter; this was always passed in great quantities after purgatives were given.

M. Eisenmann considers *Lussana* as the first who applied pathological facts to the discoveries of Bernard.

In one case disease of the pancreas was diagnosed, but there were no fatty dejections; hence the author thought that the bile assisted in the solution of fatty matters. (In this case the existence of disease of the pancreas was not confirmed by any *post mortem* examination.)

Bridge and Wintinghaussen held the same opinion; and a case is mentioned, in which a woman, who passed daily three ounces of fatty matter from the bowels, showed, on examination after death, no trace of disease of the pancreas, but an enlarged, pale, and "bileless" liver.

Another remarkable circumstance, according to Eisenmann, is, that fatty dejections have ceased in cases where the pancreas was so indurated as to have been unable to discharge its functions. He also observes, as remarkable, that the quantity of fat passed is often greater than is contained in the food; and hence he thinks that a part of the fæces are converted into fat.

In conclusion we are told that observation shows that the existence of fatty stools indicates the probability—though not the certainty—of some disturbance in the functions of the pancreas; but, on the other hand, the absence of fat in the dejections does not authorize us to doubt the existence of pancreatic disease, if the signs of such an affection are present.

[The occurrence of fatty stools in pancreatic disease is no new discovery. Twenty years ago, papers on the subject, by Drs. Bright and Elliotson, and Mr. Lloyd, appeared in the Med. Chir. Transactions, Vol. XVIII. Of these, Dr. Bright's is especially valuable. After detailing the cases, this author observes:—"In all of these, chronic ailments terminated sooner or later in jaundice; and in all of them a great peculiarity in the character of the dejections existed. In the result of the examination after death, we have likewise some circumstances which coincide in all—obstructed biliary ducts, liver gorged with bile; fungoid disease attacking the head of the pancreas, and malignant ulceration on the surface of the duodenum." On analysing these several changes, Dr. Bright considers that the particular symptom referred to is probably associated more directly with the two last conditions. From the preceding cases, and others which have appeared from time to time, it would appear that the malignant nature of the disease is not essential to its production.

Further clinical observation is required to elucidate this subject, which is here but briefly alluded to; like the functions of the pancreas itself, this question may be as yet considered as an open one.—Eds. Dublin Hospital Gazette.]

SELECTIONS FROM BRITISH AND FOREIGN JOURNALS, &c.

Dislocation of the Upper Extremity of the Radius in very young Children. By M. Bourguet, Aix.

"There exists a displacement of the radius which is only met with in children of a very early age, and which is produced when the forearm being already pronated, the motion of pronation is carried yet further, as for example by the raising the child by the hands. This displacement has been described by M. Goyrand, in 1837, as an incomplete luxation of the head of the radius. This opinion, adopted by most surgeons, has been rejected by M. Gardner (1837) and M. Rendon (in 1841), who supposed that this pretended dislocation is resolved into the passing of the tubercle of the radius behind the edge of the ulna, which then holds it there in its new position."

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* Article "*Pancreas*," Todd's Cyclopædia, Part XLIV.

This view has not been generally adopted, because the interosseous space in children is always too large to allow of the tuberosity of the biceps hitching on the edge of the ulna. M. B. admits the displacement of the bicipital tubercle, but explains its remaining thus fixed by supposing that a bundle of the fibres of the supinator brevis, interposing between the radius and ulna, catch on the tubercle, and thus keep it fixed. Hence M. B. "formules" the treatment: "Carry the forearm into forced supination, making slight extension." This mode of treatment has always succeeded in the numerous cases in which he has been called to treat, what he terms an "*enroulement*" of the bicipital tuberosity.—*Gazette Médicale.*

[This accident, the first account of which is attributed to Goyrand, was first accurately described by Mr. Adams of Dublin,* who named it a "subluxation of the upper extremity of the radius, with elongation of the coronary ligament." From him we learn that the accident was originally described by Boyer. There is nothing in the preceding account which is not described by Mr. Adams, so much so that there is even a suspicious similarity in some of the passages, as for example in the description of the manner in which the accident usually takes place. The mode of remedying the displacement is likewise that recommended by Mr. Adams.—EDS. DUB. HOSP. GAZETTE.]

Urethrotomy.

The operation recommended by M. Maisonneuve for the "immediate cure" of stricture of the urethra, noticed in a recent number of the DUBLIN HOSPITAL GAZETTE (No. XIII., Vol. II., page 205, August 1st, 1855), has been the subject of numerous discussions in the Medical Societies of Paris. The originality of the operation, its suitableness, and the terms by which it has been introduced into notice, have all been closely criticised. The originality of the operation has been called in question by M. Leroy Etiolles and Heurteloup, both of whom claim to have been the authors of similar modes of operation. The former enters very fully into the history of the different proceedings recommended for the mechanical division of stricture, in a letter read before the *Academie des Sciences*, June 11th, from which we shall give some extracts. The mode of operating proposed by M. Maisonneuve consisted, it may be remembered, in passing an instrument containing a blade over a small gum elastic bougie, and dividing the stricture from before backwards; a more extensive incision was then made from behind forwards by means of a second instrument. "Is there any novelty in this proceeding?" asks M. Leroy Etiolles. "History," he adds, "will give the reply. Scarification and division of the stricture from before backwards, without a conductor, are described in the work of Ambrose Parè and of Alfonse Ferey. Such an operation was performed on Henri IV. by *Mayenne*. A thin conductor containing a blade was invented by *Dr. Physick*, of Philadelphia. Other instruments are then mentioned as having been employed by *Amussat*, *Ricord*, *Bonnet*, of Lyons, and *Reybard* (who was in consequence awarded the Argenteal Prize by the *Academie de Medicine*).

The instruments of *Stafford*, so well known in this country, are then enumerated, but the name is erroneously given as Strafford.

It also appears that the author himself brought into notice in, 1832, an operation very similar, but, as he believes, much simpler and very superior to that of M. Maisonneuve for the purpose of making the second incision, or that from behind forwards. Maisonneuve employs an instrument similar in all respects to the "lithotome caché" of *Frere Côme*, the curve of which is increased, but the principle is unaltered. Such was essentially the mode of proceeding adopted by Reybard, already alluded to. Having thus dealt with the question of originality, he criticises the term of "immediate cure," applied to his proceeding by M. Maisonneuve:—"A patient in whom you divide a stricture is not cured, there is a wound of the urethra which requires to be healed without urinary infiltration, and without secondary contraction. In the same way, a patient affected with calculus is not cured, because you have just cut him for the stone; he is cured of the calculus, but is not free from those accidents which may supervene as the result of the operation."

M. Roberts discusses very fully the question of urethrotomy in general, in a communication made to the *Société de Chirurgie*, from which we give the following extracts:—"When M. Maisonneuve brought forward urethrotomy as 'a radical and instantaneous cure of stricture,' the Society was much excited, and demanded to know by what facts he supported an operation the results of which seemed so extremely marvellous and incredible. For my part, I cannot admit that an operation which sprang into existence but yesterday can promise a radical cure, when every one knows that time only, and even a long time, is necessary to decide upon the cure of stricture . . . . I crave permission of the Society to make a few remarks upon the manner in which urethrotomy in general should be regarded. Dilatation, as is well known, is the method generally employed in the treatment of stricture. Sometimes this is combined with scarifications or deeper incisions of the diseased tissues; these various bloody (!) proceedings are, properly speaking, but auxiliaries to dilatation, which still remains the principal method. Now, it is generally understood that this treatment is but *palliative*, and that its efficacy is scarcely ever more than temporary. M. Reybard, better, perhaps, than any one else, has stated the reason: it is because that in stricture the mucous membrane is converted into a fibrous tissue, which is contractile and elastic, like the tissue of cicatrices. In a word, mucous membrane here no longer exists, and no powers of art can re-produce it. Hence, surgeons, after treating a stricture by dilatation, always advise their patients to introduce a catheter from time to time, so as to prevent fresh contraction, a precaution either illusory or too frequently neglected, for it generally happens that those we treat, either in hospital or in private practice, come back to demand again our assistance. Notwithstanding these inconveniences, dilatation alone is suitable to the great majority of cases, for it can be employed without danger, and it is capable of preserving a functional integrity of the urethra, which is almost identical with a condition of perfect health. But there are cases where it is altogether insufficient. I now allude to those hard, callous strictures, which engage sometimes the entire thickness of the walls of the urethra. These are especially met with as the result of ruptures of the canal, or of violent blennorrhagic inflammations; they are seated more usually in the scrotal or penile portion of the canal, and they are here easily recognized by the touch—sometimes as an annular ring, sometimes oval or fusiform, and of considerable length. We know that frequently all known methods of cure fail in cases of this kind. Dilatation alone is useless—even deep incisions, unless they are carried a good way beyond the limits of the disease, are incapable of resisting the tendency to contraction; and this tendency is so rapid, that in spite of the daily use of bougies, the canal will become narrower and narrower until there is danger of the channel being altogether obstructed. I appeal to the experience of all my colleagues and ask them, if they have not seen many cases of this kind, and if, like myself, they have not been in despair at the impotency of the usual methods of treatment. It is under such circumstances that we are to set a just value upon urethrotomy, according to the method of M. Reybard."

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* Todd's Cyclopædia, Article, "Abnormal Conditions of the Elbow Joint."

This surgeon was led by the following chain of ideas to adopt his particular method. At first he used to employ a number of superficial incisions on the surface over the stricture. This proving useless, he had recourse to deeper incisions, such as are employed at present by M. Civiale. The results being scarcely more advantageous, he employed free incisions passing through the entire thickness of the walls of the urethra; the borders of the wound being kept separated, a large cicatrix is obtained, the surface of which augments the diameter of the urethra.

M. Reybard, we then learn, instituted a series of experiments upon animals, in order to study the pathological changes produced by such incisions, from which it appears that when a longitudinal incision is fully made through the mucous membrane and the edges kept apart, a cicatrix is obtained, the properties of which are very remarkable. It appears as a thin smooth pellicle, not differing in appearance from the urethral mucous membrane, and not possessing that contractility which is so characteristic of the ordinary "tissue of cicatrices." This cicatrix, being added as it were to the walls of the urethra, increases their extent, and thus the narrowing is remedied. A commission, it appears, was appointed by the *Académie*, who verified all the facts announced by M. Reybard. It remained to be proved whether the same results would follow in the human subject. A man died, in whom such an incision had been made a good while previously. M. Berard examined the specimen, and gave the following report:—"At the line of the incision the urethra presented a perfectly smooth appearance; there had been neither effusion of blood nor extravasation of urine. The former incisions were cicatrized, and the pellicle of the cicatrix was smooth and supple; opposite the incisions the urethra had acquired considerable dimensions." This case proves the possibility of the radical cure of stricture.

Several distinguished surgeons of Lyons who witnessed many cases thus operated on, have testified to the patient remaining well two, three and four years afterwards. M. Robert, continues:—"I do not pretend to say that this operation is always successful, or that the patient is not in danger of relapse. In fact, such will occur whenever acute inflammation and suppuration supervene on the operation." Accidents may follow, and constitute an objection to urethrotomy in general, but they should not lead us, in the opinion of M. Robert, to reject it altogether. Even the simplest operations, he adds, are not exempt from this risk; we have seen the simplest scarifications followed by abscesses and death. The deeper incisions adopted by M. Civiale are not exempt from these either. On the other hand, when all other means have failed, are we not authorized to adopt the remedy most likely to succeed in spite of the dangers which attend it? The sagacity of the surgeon is to consist in limiting urethrotomy to these cases in which alone it ought to be employed. In conclusion he strongly recommends the operation of M. Reybard in preference to every other.

[NOTE.—We cannot understand why the operation of Syme is not alluded to by our French contemporaries. His plan of freely dividing the stricture by cutting through the entire thickness of the urethra from without, is that which is recommended by M. Reybard to be effected from within. We conceive the risk of urinary infiltration to be infinitely greater in the former than in the latter; whilst the experiments alluded to by M. Robert may be quoted as favouring the operation of Syme, as much as that recommended several years ago by Reybard. As bearing on the same point, we may ask the question, whether or not stricture is apt to follow the incisions made into the urethra in lithotomy? We believe not; we never saw or heard of such a result. The experiments of Reybard would explain why this should be the case.—EDS. DUBLIN HOSPITAL GAZETTE.]

Complete Division of the Trachea.—Recovery.

M. Richet mentions a case of a man, 37 years of age, who, in a fit of despair, cut his throat with a razor. When brought to the hospital, the pupil on duty found the trachea completely cut across, and the lower end so retracted that it was hidden behind the sternum; by means of a tenaculum he drew it out, secured it by ligatures, and introduced a canula.

Next day it was ascertained that the trachea was severed between the fourth and fifth rings; the section was very oblique; when not restrained, the lower end of the tube passed completely below the sternum in inspiration—during expiration it ascended; the fibres of the œsophagus could be seen at the bottom of the wound—their contraction when the patient swallowed liquids was evident; fluids did not escape through the wound; any attempt at bringing the cut ends of the trachea together threatened suffocation; the edges of the tube were allowed, therefore, to remain, as they were inclined to be, widely separated; the wound was simply dressed, and the tube kept in. Two days afterwards a kind of intermediate canal existed between the two ends of the trachea, bounded behind by the œsophagus, and on each side by the lobes of the thyroid gland. Some time afterwards the wound had greatly contracted, but the patient could not breathe without the tube. The œsophagus now bulged greatly forwards, forming a kind of spur, which greatly interfered with the free escape of air. An ingenious kind of tube was now made expressly for the patient, consisting of a portion passing down into the lower portion of the trachea, of another passing up into its upper portion, whilst a third came forwards at right angles through the external wound; lastly, a moveable valve was introduced by which the patient was enabled to speak.

[How exactly this was effected, does not clearly appear.]

The apparatus was not put *in situ* without considerable difficulty, but it fulfilled all the proposed indications.—*Bulletin General de Thérapeutique.*

Tuberculous Perforation of the Left Lung; Pneumothorax; Air wholly replaced by Pus; Life prolonged ten Months after the Perforation; Death by Pericarditis.

[We copy from the Transactions of the Cork Medical Society, published in the current Number of the Dublin Quarterly Journal, the following very interesting case]:—

John Leary, aged 24, labourer, was admitted into the North Infirmary August 5th, 1854. He had been ill with cough several months; about two months ago he had copious hæmoptysis, but no pain of the chest. On admission he had a hard and frequent cough, with a metallic resonance; expectoration in greenish purulent masses; and considerable dyspnœa, less in the recumbent than the erect position; the cough also was increased by sitting up. Pulse 108, while he lay down, but rose to 120, when he sat up; decubitus was solely on the left side; there was total absence of pain, but a feeling of weight along the sternum. The left side of the chest measured three-quarters of an inch more than the right; its mobility was impaired; respiration 34; the dulness was total at the left side below the mamma; above it the sound was very clear, but scarcely tympanitic; no respiration was audible in the left lung, except a little below the clavicle and above it, and in the interscapular region. Amphoric cough and voice were heard beneath the inferior angle of the left scapula, at which place a distinct splash was audible, with a distant, echoing, amphoric sound; the metallic tinkling was not heard at *any* period of the case. The existence of air in the pleura was further proved by placing him on the right side and percussing the left; the lateral regions of the left, which were previously dull, became remarkably resonant. The heart was greatly displaced, being seen to beat under the right nipple, its sounds were exaggerated in strength and loudness, but otherwise normal. The right lung exhibited increased but healthy respiration, he never experienced a sensation of anything giving way in the chest. From this time to the end of January he presented much the same symptoms, with the exception of the gradual ascent of the liquid contents in the left pleura, and the decrease of the gaseous. The splashing sound continued to be heard from three to four months; he became so accustomed to it that it afforded him amusement to exhibit to the students his novel acquirement. It was heard at first posteriorly and laterally, but as the level of the liquid rose, it ceased to be audible in those regions; but for a long time afterwards could be distinguished in front, a little above the nipple. His voice was always hoarse. Amphoric resonance in coughing and speaking continued to be heard about an inch below the left clavicle, until two months before his death. Subsequent to this, percussion proved the total disappearance of air from the left cavity of the thorax, and the substitution of liquid contents.

It was noticed by himself as well as by the pupils, that as the case progressed, the displacement of the heart was less than at the beginning, the apex having receded nearly an inch from its first position. Except frequent attacks of hæmoptysis and epistaxis, and paroxysms of cough and dyspnœa, little apparent change took place till he left the infirmary, at the beginning of April, 1855. Upon his readmission, four weeks after, a great change for the worse had occurred. He had been exposed to cold and distress in the interval, and the slow progress of the disease had been fearfully accelerated. No respiration whatever could now be heard under the left clavicle; the vocal fremitus had ceased to be distinguished both there and near the spine; the cough had become suffocating; breathing stridulous; voice whispering; face turgid and purplish. The dimensions of the left side had greatly increased. The heart, which previously had become much lowered in action, was seen again to beat forcibly, and to strike a little to the inside of the right nipple; the sounds had increased in loudness, but were without murmur; the action had also become irregular; no friction sound was heard. A few days afterwards a sudden exacerbation came on, and he died, suffering great distress, but retaining his faculties to the last.

Before opening the body, the circumference of the thorax was measured by the house surgeon, and amounted to 38 inches below the nipples; the left side was 1¼ inch wider than the right; the left intercostal spaces were broad and smooth, but not bulging; the left clavicle was pushed upwards and forwards, and the sternal end of it was slightly dislocated; venous congestion was much marked in the superficial veins of the left arm and thorax.

The abdomen was first opened in order to get a view of the diaphragm. Upon making an incision the stomach appeared to have been subjected to great pressure, as it burst forth until it was wholly extra parietes; it had pushed the liver to the right side, the inner edge of the left lobe lying in a vertical line drawn from the right margin of the sternum; the liver had been displaced upwards at the expense of the right cavity of the thorax, while the pyloric end of the stomach had descended considerably into the abdomen. The right ala of the diaphragm was pushed upwards to the fourth rib; the left, viewed from below, was protruded downwards in a tense convex pouch, the point of its greatest convexity reaching the level of the umbilicus; the spleen lay obliquely between it and the stomach, and was small, and full of grumous blood. It was completely displaced, being brought near the median line. The difference of situation between the two wings of the diaphragm was 8½ inches. On dividing first the right intercostal cartilages, the heart was found pushed completely beyond the left margin of the sternum, and encroaching upon the right cavity of the pleura, the apex lying vertically about an inch from the right nipple; the pericardium had contracted sterno-costal adhesions; the right lung, at its anterior edge, was also adherent to the mediastinum; it did not collapse; a few lobules were hepatized, and miliary tubercles were thinly scattered through it, clustering together about the root. The left pleural cavity was carefully examined for air, but none could be detected; it was full of liquid, varying in consistence; the upper portions were like whey, the pus globules subsiding; at the bottom of the cavity there were thick yellow masses resembling butter; the effusion was inodorous. Twelve pints were removed, leaving some still behind; here the diaphragm, after the thorax was emptied, hung down in loose folds. The left lung was reduced to the size of an orange, the apex was pushed back from the clavicle, but adhered to the posterior walls by dense adhesions. On looking for the perforation, an orifice in the upper anterior portion was seen, plugged with lymph and communicating with an anfractuous cavity as large as a walnut, lined with white bands; little of the natural texture of the lung remained; it was studded with cheesy tubercles of various size, and was encircled by a layer of false membrane, so that its expansion was an impossibility. The whole of the left costal pleura was corrugated and coated with lymph; the diaphragm especially was greatly increased in thickness by layers of false membrane. The liver weighed three pounds nine ounces; it was much softened. The pericardium had contracted adhesions to the left half of the heart in a vertical line; over the right half layers of lymph had been effused, and connecting bands were commenced to be thrown out to the pericardium; the partial attachment of the heart to the pericardium and the sternum seemed of recent occurrence. No change had occurred in the internal lining membrane or the valves.

A few observations may be made on the above case:—

There was a want of conformity between the extent of the disease and the symptoms; during his stay in hospital the patient never complained of pain, even during the final attack of pericarditis. The dyspnœa also, though at times considerable, was very endurable. The present case was an example how in some habits great lesions of important organs are quietly submitted to by the economy, if not too speedily induced. Here one lung was totally useless, and the motions of the other were impeded by the difficulty which the right wing of the diaphragm experienced in descending, by the advance upwards of the liver.

It was remarkable that the effusion of air caused equal, if not greater displacement of the heart than was subsequently produced by the liquid contents. This is at variance with the received opinion, that liquids displace organs more than gases.

At the termination of the case the diaphragm appeared the most displaced by the liquid contents, the mediastinum next, the rib-spaces the least; at the beginning the mediastinum appeared to yield the most.

The decubitus, from the outset to the close of the case, never varied from the left side, thus forming an exception to the rule proposed by the late Dr. R. Townsend, that decumbency on the affected side does not occur when the air exceeds the liquid.

The inflammation of the pericardium, which was of the dry kind, was probably induced by extension of the inflammation to the contiguous parts. It is singular how seldom this complication is met with in pneumothorax of the left side. The signs of pericarditis, often latent in such cases, are very doubtful. In the present the only indications were, a sudden aggravation of the pulsation and sounds occurring after a long-continued abatement of them. The increased action of the heart, which occurs at the beginning of displacement, not unfrequently subsides after a time; its recommencement then denotes new features in the case; the irregularity of the action might also guide the diagnosis; friction sound was not heard at any time during the stay of the patient in hospital. Perhaps, in a case like the present, after dimidial adhesion of the pericardium in the longitudinal direction has occurred, especially when attachment to the sternum coexists, friction sounds might not be found.

The empyema in the present case did not arrest the hæmoptysis. According to Professor Walshe the pressure of the fluid on the diseased lung prevents effusion of blood from it. The other lung, in this instance, was probably the seat of the hæmorrhage.

Case of Traumatic Rupture of the Duodenum. By ALEXANDER THOMSON, M.D., Edinburgh.

W. S., a healthy boy of thirteen years of age, was engaged in taking down fruit from a tree, on Monday, the 21st August, 1854. In the act of reaching up, the branch on which he was standing gave way; he was precipitated with violence to the ground; he fell with his belly on the branch, which was found lying beneath him; when raised, he was insensible, and remained for a short time in this condition. In the course of the afternoon he recovered, and appeared to be perfectly well. He came up to Edinburgh from Musselburgh on foot (in the evening), went to the west end of the town to visit a relation, and next day returned to Musselburgh, making no complaint whatever. During that afternoon he was out playing with his companions on the links. His friends relate that his illness first attracted their attention on the evening of Wednesday the 23rd, when he began to complain of sickness, and of a pain situated immediately below the arch of the ribs on the right side. Vomiting set in late that evening, and was accompanied with a marked degree of pallor, increasing sickness, and constant desire to go to stool. The bowels had been moved without medicine early in the afternoon of Wednesday, but after that time no evacuation from the bowels took place. The case assuming a serious aspect, he was brought to Edinburgh on Friday the 25th, and placed under my care.

Symptoms.—His pulse was soft, feeble, and rapid. The vomiting still continued. There was no tension of the abdomen, which was relaxed and flaccid, without the slightest tenderness to the touch. He only complained of a dull constant pain under the right hypochondrium, at the seat of his previous injury.

Treatment.—The treatment consisted of small doses of cal. and opium ænemata, with fomentations, and the administration of wine and beef-tea. An eminent physician was called in consultation on the Sunday, August 26, who, under the apprehension that it might be a case of subacute peritonitis, recommended the application of leeches. Four were applied over the seat of pain, and bled moderately. Even that small abstraction of blood appeared to be badly borne, as the patient rapidly sank, and died that night.

Sectio Cadaveris.—The friends only permitted an inspection of the abdomen, in conducting which I was assisted by Dr. Littlejohn. The peritoneal cavity contained a small quantity of almost colourless serum. On turning aside the bowels, which presented nothing worthy of remark, the descending portion of the duodenum was found of a brownish colour, and on its outer side there was a well-marked tumour, about the size of a turkey egg, which was at first mistaken for the kidney, but which was found, on incision, to consist of a dark coagulum of blood. The stomach was now opened, and the duodenum was carefully split along its exterior surface. At the lower part of its descending portion, just as the gut begins to pass transversely, a black coagulum of considerable firmness was seen protruding into the cavity of the intestine, and on its removal disclosed a linear rent on the outer and back wall of the duodenum fully an inch in length. On passing the finger through the aperture, it was found to lead into the cavity of the large clot, which had at first attracted notice. No blood could be discovered in the intestinal canal. The coats of the duodenum were not softened, and gave out no perceptible odour. Along the transverse portion of the gut, blood had evidently been extravasated between the mucous and peritoneal coats.

Commentary.—The chief point of interest in the case is the lapse of time which intervened between the receipt of the injury and the occurrence of the more serious symptoms. It is difficult to believe that so severe an injury as rupture of any portion of the intestinal canal should for so many hours be unattended by symptoms likely to attract the attention of watchful relatives. But here we have an injury quite capable of producing the lesion in question received on Monday; the boy able to come up to Edinburgh the same day, during this journey undergoing a great deal of fatigue, and for two and a half days making no noticeable complaint. It is probable that an explanation may be found in the peculiar site of the rupture. The resisting surface of the small clot which protruded through the rent into the cavity of the intestine, appeared to be formed by a delicate transparent layer of cellular tissue, and it is possible that during the prolonged insensibility that followed the receipt of the accident, hæmorrhage took place into the lax cellular tissue, in the immediate neighbourhood of the duodenum. A plug was thus formed, and any extravasation of fluids or digested matters completely prevented. The peristaltic action of the intestinal canal, however, became seriously interfered with; no food was taken for five days previous to death, and during the same period the bowels never moved, the boy dying by asthenia—the result of the nature of the lesion and of the lack of nourishment.—*Edinburgh Monthly Journal.*

Double Vesico-Vaginal and Recto-Vaginal Fistula, with complete Destruction of the Perineum; cured by Operation.

M. Jobert de Lamballe publishes, in the *Gazette des Hôpitaux*, a very interesting case, in which the above serious, complicated, and distressing condition existed, and in which he obtained a complete and permanent cure, by operating with the view of producing adhesion of the sides of the fissures. The following is an abstract of the case:—

Madame G——, 28 years of age, uniformly enjoyed good health until the birth of her first child. The labour began, and proceeded naturally until the head of the child was in the external orifice, further than which the pains were unable to expel it. Through the ignorance and carelessness of her attendants, she was allowed to remain in this position forty-three hours, when a second physician being called, she was delivered with the forceps, the child being some hours dead. Twenty-four hours after, the patient was found to have passed no water; a catheter was passed, and a large quantity drawn off. Upon the following day the catheter was again employed, when it was found that the bladder was already empty, the bed was soaked with urine. Upon examination, it was found that the perineum and a large part of the rectum were destroyed, presenting a large ulcerated surface, exhaling a gangrenous odour, and covered with fæcal matter and bloody urine. In the anterior wall of the vagina the finger first felt the orifice of the urethra, and then penetrated directly into the bladder. The vagina, in fact, was little more than a common cloaca, in which the fæces and urine mingled. All the evacuations were passed involuntarily; the external genitals and parts around were the seat of active erythema, from the irritating urine which bathed them. In this state she came to Paris ten months after her accouchement. In the perineum was found a rent engaging the whole recto-vaginal septum. Upon separating the edges of this fissure the mucous membrane of the rectum was disclosed, the edges were red and fungous, and bleeding easily. At the entrance of the vagina was seen a reddish tumour of the size of a nut, its surface covered with mucous membrane; this tumour was formed by the anterior wall of the bladder, forming a hernia, which became evident when a sound was introduced through the urethra. About an inch behind the orifice of the urethra was the opening, which readily admitted the point of the index finger; the bladder was collapsed, and considerably smaller than natural. Further back than this fistula the finger met with morbid adhesions between the anterior and posterior wall of the vagina.

Here, then, was a case of extensive double-vaginal fistula, all the parts in the neighbourhood having suffered more or less. The condition of the patient was very wretched, her health was greatly deteriorated, and she was most anxious for anything to be done which afforded a hope of relief. Upon the 28th of May, M. Jobert operated, the patient being placed in the position for lithotomy; his first step was to make an incision behind the vesico-vaginal fistula to free it from the cicatrix which existed in this situation; then the hernia of the bladder being reduced by a sound introduced through the urethra, he pared the edges of the wound with a bistoury, and drew them together with two sutures. He then made three more incisions through the thickness of the urethra, one on each side of the fissure, the other behind it, in order to take off all strain from the sutures, and thus facilitate the union of the edges of the fistula.

The recto-vaginal fissure was then treated in a similar way; and after the edges of the wound were united with sutures, two semi-elliptical incisions were made to relieve the tension of the parts, and thus encourage the union of the fissure. A catheter was introduced through the urethra and fixed in the bladder, and the wounds being dressed and a T bandage applied, the patient was placed in bed.

Our space will not permit us to follow the daily history of the recovery, suffice it to say, that thirty-two days after the operation, MM. Jobert, Hervez, and Chégorin examined the state of parts, and found the two fissures closed; the recto-vesical fissure was firm and resisting; the perineum was perfectly reformed, and nearly of its natural size; all communication was intercepted between the bladder and vagina, which was perfectly dry. The patient can retain the urine when lying down; she is necessitated to pass water two or three times during the night, when she is up the calls are still more frequent. The neck of the bladder does not seem as yet to have recovered the necessary energy to retain the fluid accumulated in it, and the capacity of it is as yet small; the vagina is terminated by a cul de sac resulting from the adhesion of the opposite walls. The general health is good.—*Gazette des Hôpitaux.*

Spontaneous Cure of Intussusception by Sloughing of the strangulated Portion.

The French and English periodicals have each recently contributed a case of this very unusual termination of intussusception. The one is given in the *Gazette Medicale,* the other in the *Lancet.*

Case I.—The particulars of this case, and the portion of the intestine which was expelled, were laid before the *Academie de Medecine.* The case was treated by M. Hallaguen of Châteaulin. The patient was a woman of 47 years of age, who, for several days, laboured under the symptoms of volvulus. At last there were copious dejections for forty-eight hours; the stools became fetid, and at last possessed a gangrenous odour: there were now violent abdominal pains and symptoms of impending dissolution. The next day relief was experienced, and a portion of large intestine, several inches in length, was passed *per anum.* Perfect recovery ensued.

Case II.—This case is published in the *Lancet* (August 18) by Mr. Sang, of Newcastle-upon-Tyne. In this instance a large portion of the ileum sloughed away. The case is thus narrated:—

"I was requested to visit Jane A——, aged twelve, on the evening of the 29th of April, 1855. She complained of great pain in the right side, a little below the ribs. There was evident enlargement, about the size of a goose's egg, which gave severe pain upon pressure, and was attributed to carrying a heavy basket of potatoes, which pressed much upon the side. She suffered also severely from vomiting.

"Leeches were ordered, to be followed by a large poultice, with small doses of calomel and opium, which gave partial relief. Other medicines of a laxative nature were given to her, but these she repeatedly vomited, and, indeed, almost everything was rejected, and in consequence I left off giving medicine, as it only seemed to aggravate the disease.

"On the 3rd or 4th of May, vomiting of feculent matter commenced, and continued almost daily until the 17th. The bowels were much distended, painful, and tympanitic. A large blister was applied, and occasionally turpentine, outwardly, and by injection. Injections of soap-and water were used two or three times a day, with warm applications over the bowels, and on the morning of the 9th of May a portion of the ileum, about twelve inches in length, was passed *per anum.* For two or three days after this she was comparatively easy; had no vomiting; bowels acted naturally, but there was considerable difficulty in passing urine; pulse 112; tongue moist.

"May 14th.—Slight vomiting of feculent matter; bowels freely moved by injection. Slept tolerably well.

"15th.—No vomiting; restless in the night; bowels slightly moved by injection; passed urine more freely, and was much relieved; pulse 114; bowels still large and painful. Poultices were almost daily applied.

"16th.—No vomiting; otherwise much as yesterday.

"17th.—Vomited a large quantity of feculent matter last evening; afterwards passed a good night; urine more copious; very weak. The food to be entirely of a farinaceous character.

"18th.—Vomited again last evening; passed a quiet night; tongue moist; pulse 120.

"19th.—No vomiting; bowels twice naturally moved; pulse 104.

"21st.—Continues to improve.

"24th.—No vomiting since the 17th; used an injection occasionally; pulse gradually coming down.

"June 1st.—Doing well; no bad symptoms.

"14th.—Quite recovered; bowels act naturally. Her health is better now than it has been for some years; her appetite is very good, but still restricted chiefly to farinaceous diet, and occasionally a little beef-tea.

"It appears that at the age of two years she had symptoms of marasmus, and continued in a very weak state of health for three or four years. Since that time she has frequently complained of pain in her bowels, followed occasionally by severe purging usually in the spring of the year.

"Such is a brief outline of the case. No doubt, in the first instance, it had been one of intussusceptio, but Nature had exerted her wonderful restorative powers, and satisfactorily completed what the ingenuity of man would fail to do."

Pathology of the Urine in Mental Diseases. By C. M. Burnett, M.D.

[In the reports of the Reading Pathological Society, published in the Association Journal, we find the following communication by Dr. Burnett, on the state of the urine]:—

Dr. Burnett read a most able paper on the state of the urine in mental diseases, and the importance of the application of the study of organic chemistry in the investigation of those diseases. He showed that the constituent materials of the brain vary in their relative proportions, and that while in the one class of cases we find there is a deficiency of some constituent, as phosphorus, in another class we get the same substance in excess. The brains of maniacs contained, as a general rule, an excess of phosphorus, while those of idiots had less than the normal proportion.

After dwelling on the many difficulties that beset our path in the study of animal chemistry, and showing that we are almost in total darkness with regard to the nature of the changes that take place in our bodies, the author proceeded to remark that in one case of acute hypocondriasis, where crystals of oxalate of lime were abundant in the urine, the symptoms were much diminished when these were got rid of by persistent therapeutic and hygienic treatment. But in another case, one of acute mania, where these crystals were also abundant, the maniacal symptoms disappeared and the health improved, after an attack of nine months, the crystals continuing to be formed as usual.

Dr. Burnett had observed the earthy phosphates in the urine in recent and old cases of mania, in cases of dementia, and of melancholia. In one case of intermittent mania, he observed that crystals of the triple phosphate returned with every recurring paroxysm. The diseased action of the skin, frequent in mental diseases, especially when occurring in the female sex, and the value of the free use of the warm bath, seem to show the value of giving assistance to the excretory functions; getting rid of the lower organic unions, which probably have a greater tendency to form under such circumstances of impaired vital power. On the other hand, the effect of cold is well known as an exciting cause of mental disease. The delirium which accompanies the several forms of fever seems to be the result of obstruction of the functions of the skin.

The disease called pellagra, common in the south of Europe, is a cause of mental affections. Of five hundred lunatics in the hospital at Milan, Dr. Holland found more than one-third suffering from this disease. The alvine secretions are also an important channel for the removal of the earthy phosphates. The conclusion at which Dr. Burnett arrives is, that in mental diseases there is a tendency to destroy the higher organic unions, and to form unions of a looser, less complex, and less healthy character. He observes that those substances (such as the vegetable alkaloids) which have a tendency to arrest the disintegration of the higher organic unions, are just those which are best calculated to arrest the progress of decay and the advance of disease. But he does not expect that we shall find any class of substances which, by being taken into the stomach, shall reconstruct those compounds, and believes the utmost we can do will be to arrest the cause of their dissolution.

The occurrence of albumen in the urine in these cases is rare, and encourages the author in the belief that much may be done by persistent treatment, as it is an indication that, as a rule, the tissues are not involved. When the phosphates are being thrown down in the urine, our treatment should be directed to strengthen the primary and secondary processes of assimilation.

In conclusion, the author attributed much of the increase of insanity to the advance of what we call civilisation, a term embracing many customs and habits favourable to the growth of nervous disease.

Cyst from Uterus. By W. B. Young, Esq.

Mr. Young presented to the Reading Pathological Society, a large spherical substance, like a hydatid, which had been passed from the vagina of a woman, from whom he had removed a polypus uteri fifteen months before. After this, there were symptoms of purulent absorption. She had a sense of constriction across the loins, which was relieved on the recurrence of a periodical discharge of matter. About two months previous, she passed some small calculi, with what were apparently hydatids; and three weeks since, the substance which Mr. Young presented.

The Society requested Mr. Young and Mr. G. May, Jun., to be a committee to examine and report on the substances in question.

The Committee came to the conclusion that the cyst had been expelled from the uterus, and that it was not an hydatid, but probably an enlarged mucous follicle. The calculi they thought to be either degenerated hydatids or cysts. They are composed of carbonate and phosphate of lime with shrivelled membranes.—*Association Journal.*

DUBLIN: PUBLISHED BY W. B. KELLY,
8, Grafton-street.
LONDON: S. HIGHLEY, 32, Fleet-street.
EDINBURGH: MACLACHLAN & STEWART.
September 1, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.
SENT FREE BY POST.
Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 16.—Vol. II. SEPTEMBER 15, 1855. Price 5d.

Clinical Lectures on the Diagnosis of Cancer and Cancroid Growths.

BY MAURICE H. COLLIS, M.B., F.R.C.S.I.,

SURGEON TO THE MEATH HOSPITAL AND CO. DUBLIN INFIRMARY, ETC.

In this and the following lectures I purpose to give you a sketch of the leading features of cancers and cancroid growths. The advances which have lately been made in this subject render it impossible for me to confine my observations exclusively to their clinical features, without reference to the minute structure of each growth. So much new light has been thrown of late years upon the anatomy of this class of diseases by the microscope, that no clinical lecture can be complete which neglects it; for in this, as in all other branches of pathological investigation, we have every reason to say that increased scientific accuracy has led, and will lead still more to increased accuracy of practice. We have already derived considerable advantage from the use of the microscope in the study of cancer and its kindred growths, by being enabled to classify and arrange many distinct products of morbid action which were formerly confounded together. Nor has this been without practical advantage; many symptoms and appearances are now capable of explanation with some approach to certainty, which formerly only caused confusion and perplexity, at least to the juniors in the profession, and a broad distinction of treatment has been drawn in practice, according as certain clinical features have been found by experience to apply to certain kinds of growth. Thus, as we shall see further on, tumours which present one kind of organization or structure are liable, if removed, to return not only in the cicatrix, but in any part of the body; while other growths present different anatomical structure, and are either found not to recur after operation, or to recur as a rule only in the neighbourhood of the primary growth. I do not mean to say that we are indebted to the microscope for the knowledge of these and similar clinical facts, but that without the microscope we never could have ascribed to each growth its own peculiar symptoms; for the microscope alone has revealed to us an essential difference of structure, to the existence of which we were and would have remained strangers without its aid. I shall therefore endeavour to group together in these lectures the clinical features and anatomical structure of such cancerous and cancroid growths as we shall have the fortune to see examples of, in the present session, with a view to arrive at such rules of diagnosis and practice, as the present state of our knowledge on the subject will admit of, and with a desire to increase the numbers and the zeal of those who are prosecuting the study of this difficult subject in what appears to be the right direction.

Cancer is a morbid infiltrating growth, the nature of which seems to be destructive of all tissues with which it comes in contact. Whether it appear in an acute form, when it is called encephaloid cancer, or in the more chronic form of scirrhus, its special element or essential difference is a peculiar form of nucleated cell. Repeated examinations have convinced me that there is no proper stroma in cancer. The stroma of a cancerous tumour is the remains of the proper fibrous tissue of the organ in which the cancer is deposited; it often presents features of considerable clinical value, as showing the rate of development of the tumour, and it often proves a gauge of its destructive power; but it is not cancer; it does not form any part of the special organization which alone deserves the name of cancer. It may be distorted or atrophied, or it may be even hypertrophied by an effort of nature to resist the progress of the destructive deposit, but we must be careful to distinguish between the essence of a disease and its effects. The characters of this peculiar cell are as follows:—

In *size* it varies from the 1-700th of an inch to the 1-1600th; the variation depends on the age of the cell and the rapidity of the tumour's growth. The cells of encephaloid are rapidly formed in great numbers, and are smaller than the more slowly developed cells of scirrhus; in this they resemble epithelial cells, which are round and small where moisture abounds and favours rapid growth, and which are large and flattened out according as circumstances deprive them of their moisture.

The cell-wall is delicate, often not to be perceived but by an oblique arrangement of the light, or by touching them with very weak vinegar and water. Acetic acid entirely dissolves it. The typical form is round or oval; it is frequently flattened out or pressed on by neighbouring cells, and rendered polygonal or caudate; occasionally the tail-like process is elongated into a kind of fibre. In the same specimen great varieties of shape and even of size will be observed; this multiformity is a special characteristic of the cancer-cell.

The nucleus, which is contained in the cell, is much less variable in size and shape: it is large compared with the nuclei of other cells; it is oval—the long diameter is about 1-2500th of an inch; its margins are well defined, much darker than the outline of the cell-wall, and rendered more distinct by the addition of dilute acetic acid; the acid not only dissolves the cell-wall and granular blastema, but also, if not too strong, it acts directly on the nucleus, perhaps, by coagulating the albumen which it contains. The addition of acetic acid, therefore, renders the nucleus, both relatively and positively, more distinct. Occasionally a second nucleus is perceived in a cell; care, however, must be taken not to mistake the accidental super-position of one cell over another. More than two nuclei are not common, and where more than one exist, they are generally somewhat dwarfed. Nuclei are frequently found free, especially in scirrhus; they resist destructive agents, including decomposition, better than the cell-wall. Hence they are often found surrounded by the debris of the cell; and as degeneration of the cell occurs more constantly in scirrhus, this, probably, forms a sufficient reason for their being more numerous in it.

One or more *nucleoli* are generally found in each nucleus, similar, so far as present observation has gone, to the organic granules, which abound in all organizing blastema, except that they are rather larger and more sharply defined.

Beside these, the cell contains a fluid almost transparent in recent cases of encephaloid, but more or less granulated under other circumstances, and similar in all respects to the blastemal fluid in which the cells float.

Such is the typical cancer cell, the special element of cancer. It is subject, however, to degeneration in more ways than one. Hence, in every specimen we examine, much variety presents itself. The destruction of the cancer-cell appears to take place in two distinct ways: it either dries up and falls to pieces, as all cells do when dried, or it becomes the seat of an oily degeneration. In the former case the nuclei are seen more or less perfect, surrounded by the dust and fragments of the cell-wall and its granular contents; in the latter, the cell-wall is rendered more distinct, while the nucleus is proportionably obscured by the adhesion of minute drops of oil to the inner surface of the cell-wall. Cells, in this state of fatty degeneration, must not be confounded with the compound-granular cells, which are sometimes found mixed with cancer, as they are wherever active inflammation is set up from any cause. The compound granular cell is made up of an aggregation of organic granules, and has a mulberry outline; it is round, with granules of an even size, projecting on all sides, while the oily cancer-cell is smooth, and contains the oil-drops in its inside; these drops, also, are of all sizes, and the cancer-cell is larger than the compound granular cell. If to these we add the presence of more or less of the fibrous and other natural tissues of the part, we shall have a tolerable idea of what is to be seen in the microscopic examination of a cancerous tumour.

(*To be continued.*)

CASE OF LITHOTOMY.

BY HENRY THOMPSON, M.D.,

SURGEON TO THE TYRONE INFIRMARY.

The following case is contributed chiefly on account of some unusual circumstances which followed the operation, and which appear to me to render it of some interest to the readers of the DUBLIN HOSPITAL GAZETTE.

CASE.—Henry M'Cann, aged 6, a healthy looking boy, was admitted into the Infirmary, August 3rd, 1855, suffering from symptoms of continual and extreme irritation of the bladder, evidenced by incontinence of urine, and by excesive pain in passing water, which was referred to the vesical and inguinal regions, and to the glans penis, and continued for some time after each evacuation. The prepuce was lax and elongated, as it usually is in cases of calculus. The lymphatic glands along Poupart's ligaments, on each side, but particularly the right, were enlarged and tender; and absorbent vessels, as hard and prominent as pieces of whipcord, could be traced in the same situations. The child had not had an hour's sleep at a time for the previous three months, his nights being passed in running from one side of the room to the other, screaming in agony, and seeking relief by occasionally throwing himself forward over the side of the bed.

He was somewhat pale and soft, and, according to his mother's account, much thinner than he had been. From his third year he had been giving trouble, and was often blamed and corrected for wetting his bed and clothes, but he did not complain much of pain until within the last three months, during which it has been progressively increasing, with scarcely any intermission.

Not having at the moment a sound of the proper size, I passed a silver catheter, and distinctly felt a stone in the bladder. Ordered a warm hip-bath at night—a dose of castor oil, to be followed by a draught, containing four drops of Battly's sedative, at bed-time.

August 5th.—Had experienced great relief from the measures prescribed, and got some refreshing sleep. A small quantity of urine only could be collected; it was of a pale colour; acid reaction; sp. gr. 1015, depositing a light cloud of mucus, free from pus globules or crystalline deposit.

August 7th.—Sounded again, and stone felt.

Hab. olei ricini ʒii. horâ decubitûs.

August 8th.—The medicine having operated freely during the night, I performed the lateral operation at 11 A.M. in the manner very usually adopted by Irish surgeons.

Operation.—The staff was held by the operator; the first incision was made, the urethra entered, and the left lobe of the prostate divided by a scalpel with a cutting edge, somewhat less than half the length of the blade. The opening in the prostate was then enlarged with a narrow, straight, blunt-pointed bistoury to the requisite extent for the extraction of the stone, which was effected by means of a pair of polypus forceps. The entire proceeding did not occupy more than two minutes. The transversalis perinæi artery bled very freely, and seemed so large that I thought at first I should have had to tie it, but the bleeding had ceased by the time the operation was over; the bladder and rectum having been then examined by the finger and found all right, the patient was unbound and put to bed, no canula being used, nor any application made to the wound. Chloroform was exhibited and acted well, producing none of those inconvenient effects on the rectum and bladder, which have been observed in some other cases. There was no urine in the bladder, which does not appear to me to be at all a disadvantage, and must, I think, lessen, if not entirely obviate, the danger of urinary infiltration.

Three hours after the operation the boy had slept a little, but awoke in considerable pain, referred to right groin. Sheets wet through with urine; very moderate oozing of blood. Ordered four drops of Battly's sedative.

Six hours after, the urine caused smarting in the wound, which makes him very uneasy. He complained of pain in the lower part of abdomen; skin hot; pulse 140, full and strong; fomentations to abdomen, covered with oiled silk.

August 9th, 8 A.M.—Passed a restless night, frequently starting and screaming. Complained once of nausea, but did not throw up; has slept pretty well since early in the morning; now sleeping tranquilly; pain in abdomen relieved; some tenderness, and great fear of being touched anywhere, but particularly over lower part of abdomen. Four leeches to hypogastrium; continue fomentations.

7 P.M.—Has slept soundly since two o'clock; the leech-bites bled very freely; continue fomentations.

10th, 9 A.M.—Restless at first; slept since four A.M.; now asleep; respiration 30; pulse 120; tenderness continues; three leeches to hypogastrium; half a grain of calomel every second hour; ʒss. of mercurial ointment to be placed in arm-pits.

10 P.M.—Has slept a good deal during the day; when awake complains of pain in abdomen, which is very intolerant of pressure; pulse 140, softer and weaker; he is very quiet, not liking to be moved; urine flows freely; the fomentations are kept up assiduously.

11th, 3 A.M.—I was sent for, and found him in great distress, crying out with great pain in abdomen, wanting to pass a motion, and saying that he was wet. There was no wet under him; and on examining the wound I found it all closed, except the anterior part, where there was a small opening, and this was obstructed by a clot partly hanging out of it; there was decided increase of tension of lower part of abdomen—in short, he was labouring under *retention of urine*. I immediately removed the clot, passed a gum-elastic catheter into the opening, and broke up the adhesions in the rest of the wound; a quantity of urine gushed out with force; there was some swelling and hardness around the wound, but no unhealthy appearance.

8 A.M.—Has slept ever since; respiration 32; pulse 120. Considerable distention of abdomen

generally, and great tenderness; urine flows freely through wound, which has again united, except one small opening at anterior extremity; I opened it out again with the point of a catheter.

℞. Pulv. resin. scammonii,
Hyd. submuriatis, āā gr. ii.
Pulv. rhei, gr. iii.
Theriacæ q.s. ft. pil. iv.
Statim sumend.
Haust. olei Ricini ʒii. post horas quatuor.

10 P.M.—Soon after taking the castor oil had three copious evacuations of dark, tarry stuff, followed by complete subsidencc of the distention, and great diminution of the tenderness. He has since slept easily and tranquilly; pulse 112; respiration 20; still asleep.

12th.—Slept all night; bowels open again; swelling and tenderness of abdomen gone, except in vesical region, where there are fulness, hardness, and considerable tenderness still. A warm hip bath; no medicine.

13th.—No change; allowed some chicken broth.

14th, 2 P.M.—A purulent discharge in considerable quantity has appeared on the sheets, and flows from wound on pressure above pubis, which is now borne without much complaint; skin cool; pulse 100; appetite good; a mutton chop and potato for dinner.

15th.—Slept well; purulent discharge continues.

16th.—The swelling above pubis admits of being grasped in the hand, and occupies the situation of the bladder; on pressing it the pus flows freely; strength improving.

18th.—Complained this morning of smarting along urethra, and a sensation as if the urine partly entered the passage; no urine has as yet appeared *per urethram*, and this is the tenth day. So, calling to mind the attack of retention, which I could only explain by supposing the existence of a clot in the urethra, similar to that which I had removed from the wound, I thought the time had come for endeavouring to remove this impediment; and with considerable difficulty, arising from his violent opposition, I succeeded in getting a No. 6 gum-elastic catheter into the bladder; a slight obstruction was felt at the membranous portion, but it yielded easily. A little blood appeared at the wound, and when the instrument was withdrawn, about a teaspoonful of urine, slightly coloured, followed it from the urethra in a gush. A warm hip bath.

19th.—No urine *per urethram;* vesical tumour softening and diminishing; matter still flows, on pressure, from wound; passed catheter again, a teaspoonful of urine gushed through the instrument when it reached the bladder, and a little blood appeared at the wound; the bladder now retains the urine sufficiently long to enable him to give notice when it is about to flow.

21st.—Some drops of urine were passed *per urethram.*

23rd.—Passed an ounce of urine to-day in a full stream, without pain or forcing; it was of a pale colour, and on standing deposited pus, the supernatant fluid being very slightly albuminous.

27th.—The urine has ceased to flow by the wound, which is rapidly healing; the granulations are touched with nitrate of silver occasionally.

29th.—Retains his urine longer; wound almost healed; allowed to get up; proportion of purulent deposit less.

30th.—Deposit now more in the form of a mucous cloud; it still, however, contains a few pus globules, but they have a small, shrivelled look, as if not freshly secreted. In addition to a few small epithelial scales which I have not observed before, and a few fibrinous shreds as of decolorized coagula, there is a marked quantity of lithic acid crystals adhering to the sides of the vessel, and in greater numbers at the bottom. Brandish's solution, five drops three times a-day in a little cold water.

31st.—Up every day now; and every day improving in the power of retaining his urine; general health excellent.

The stone was of the mulberry kind, of a dark yellow colour, extremely hard, and nearly spherical in shape. It measured two inches in one circumference, and one and three-fourths in the other, and weighed two drachms.

The occurrence of retention of urine on the third day is remarkable, and only to be accounted for in the manner explained above; under other circumstances it might have been as well to have passed the catheter by the urethra at once, merely removing the small clot which obstructed the opening *in perinæo*, without breaking up the entire wound again, but in this case the following considerations determined me on the course I pursued. Acute inflammation existed, engaging, as well as I could determine, the cellular tissue surrounding the neck of the bladder, likely to end, as it did eventually, in suppuration, which would require the opening to be kept free for its discharge. Besides, the patient had such an objection to the introduction of an instrument, and struggled so violently against it, that I feared the excitement might determine the extension of the inflammatory action to the peritoneum, respecting which I was somewhat apprehensive.

As a preliminary proceeding, I preferred a purgative the night before to an injection on the morning of the operation, having observed a portion of the injection often retained and passed while the incisions were making, to the great annoyance of the operator. The intestine contracts better under the influence of a purgative, which also empties the upper portions of the canal, and admits of more perfect quiescence subsequently.

The persistence of a degree of incontinence of urine somewhat longer than usual is due to the extreme irritability of the bladder, which, for three months previous to the operation, had given up its function of reservoir altogether, and discharged the urine as fast as it entered it, and for some years before matters had been very little better in this respect. Under these circumstances, the organ seems to be resuming its natural powers as rapidly as can be reasonably expected.

OBSERVATIONS ON A CASE OF FEVER COMPLICATED WITH DISEASE OF THE MITRAL VALVE.

BY DR. LEES,

PHYSICIAN TO THE MEATH HOSPITAL.

Although the condition of the heart in fever has had much light thrown on it by the researches of my colleague, Dr. Stokes, yet, as his labours have been directed chiefly to the affections of its muscular structure, and to the diagnosis and treatment of this state, I think it may prove both interesting and important to direct the attention of the profession to diseases of the mitral valve as forming a very serious complication, and necessitating a very cautious prognosis when we meet it associated with fever, as was well exemplified in the following case:—

Mr. H., æt. 33, of active and temperate habits, but of a very bilious temperament, was attacked with the ordinary symptoms of fever last August. I saw him on the fourth day of his illness, he looked very haggard and pale; complained of headache, want of sleep, nausea, flatulence, and constipation; his tongue was coated with a thick fur; pulse very quick, small, and irregular; the impulse of the heart was strong but irregular, and accompanied with a slight roughness, but no murmur; the maculæ appeared on the sixth day of his illness, and he went on very well until the eighth day, when his breathing suddenly became much hurried and laboured, attended with a constant short cough, and palpitation. He was very restless, bled from the nose, and also expectorated some very florid blood. Sir H. Marsh now saw him, and on examining his heart pronounced an unfavourable prognosis, which was unfortunately soon verified, as he rapidly became worse, bathed in profuse perspiration, and died suddenly on the ninth day of his illness.

I examined his body forty-eight hours after death; the weather was very warm, and decomposition had advanced rapidly, particularly in the thorax, which was much discoloured. On opening it the pericardium appeared much distended, and on dividing it the heart protruded, inflated with gas, and giving a tympanitic sound on percussion; on dividing its large vessels a quantity of very fluid blood escaped, and the heart collapsed like a wet cloth, all its muscular substance being quite flaccid. I examined it carefully next day with Sir H. Marsh and Mr. J. Hayden. We found the left ventricle dilated to twice its natural size, but not hypertrophied; the posterior segment of the mitral valve was rigid and long, so as to allow of regurgitation; the musculi papillares were all greatly hypertrophied, proving that the disease must have been of long standing. There were no traces of any *recent* disease in the heart, lungs, or in any other part of the body.

I confess, I was quite surprized at the rapidly fatal termination of this case; for although physician to the Meath Hospital for many years, during which time I have had constantly many cases of fever under my charge, I have never met with a similar complication in the course of fever. I feel quite satisfied that the disease of the heart had existed for a long time prior to the fever, not only from the morbid appearance, but also from his history: though he never complained of his heart, yet his friends informed me that he never could walk fast nor ascend heights, without suffering much from shortness of breath; and his wife told me that she had for some time observed a great beating of his heart—as she expressed it, a great knocking against the chest. Although he was maculated, yet there were no bad symptoms, nor any appearance of danger till the eighth day, when the disease of the heart became suddenly so aggravated. The small and irregular pulse had led me from the first to examine the heart carefully; and as its action and sounds were quite different from what we observe in a heart weakened from the effects of fever, I felt certain that the alteration of rhythm depended on disease of the mitral valve; but I was not aware of the very serious nature of this complication to the fever, till informed by Sir H. Marsh, who at once recognized it as similar to two cases which he had lately seen in consultation, and both of which proved fatal.

Bibliography.

Ueber den Unterschied der Contagiösen und der Miasmatischen Krankheiten, besonders über die Contagien der Pest und des Typhus, vom geographischen Standpunkte. VON DOCTOR A. MÜHRY IN GÖTTENGEN. (*Zeitschrift für Rationelle Medicin.*)

We are induced to notice this communication "On the Distinction of Contagious and Miasmatic Diseases, and especially on the Contagion of Plague and Typhus, from a geographical Point of View," inasmuch as we know of few subjects which possess more interest or are more attractive to the philosophic student of medicine.

From remote times down to the present, all that concerned the diseases which at times assumed an epidemic form, have engaged the attention and exercised the ingenuity of some of the most eminently successful cultivators of the healing art. The vast importance of the subject, the great interests at stake, the benefit to the whole human family, derivable from a discovery of the causes, and the means by which epidemics may be averted, have proved amply sufficient inducement to the philanthropic physician to enter upon this difficult inquiry. The increased interest which is taken in the subject is clearly evinced by the establishment of the Epidemiological Society, from the labours of which we may reasonably expect a large amount of highly valuable information. To German medical science we are indebted for an admirable treatise on the epidemics of the middle ages, and well and ably has the learned narrator of this black passage in history performed his task. A perusal of Professor Hecker's "Epidemics of the Middle Ages" would deeply interest even the non-professional reader. Knowing how numerous have been the labourers in the field of inquiry of which we speak, we might reasonably expect a rich harvest; but we are by no means satisfied that the results have been commensurate with the amount of labour expended.

Strange as it may appear, little in modern days has been added to the store bequeathed to us by our venerable progenitors, the divine Hippocrates, Fracastoro, and Sydenham, the immortal representative of English practical physic.

Of late there has been an energetic effort made towards removing much of the uncertainty and vague speculation, which invested the subject of contagious and miasmatic diseases, and foremost in the ranks of those who have engaged in the study of the causes from which these diseases spring, and of the mode of the operation of the poisons, by the absorption of which into the system they are produced, is the distinguished chemist, Liebeg.

Dr. Mühry, of whose treatise we propose to give a brief analysis, states at the commencement, that for both kinds of diseases, as well for those caused by contagion, as those which have a miasmatic origin, he adopts the term "zymotic," considering the name well chosen, and in general use; a term, we may observe, originally given by Mr. Farr, in the reports of the Registrar-General. The adoption of this designation implies a belief in the mode of action of poisons foreshadowed by the old humoral theory, but in our time placed on something like a scientific basis, by the investigations of Liebeg; a supposition that the poison, being taken into the blood, acts after the manner of a ferment. In a former paper, published in the *Zeitschrift für Rationnelle Medicin*, Dr. Mühry has recognized, as a distinguishing attribute of miasmatic diseases, a dependence on the constitution of the soil, on the temperature, and, in general, on the circumstances of vegetation.

Contagious diseases, on the contrary, he states, show themselves to be perfectly independent of the constitution of the soil, and generally of the condition of vegetation, as also, with one exception, of temperature and seasons. Contagion cannot exist without man; it is the communication from one human being to another of a specific poison, which, being taken into the system, has the power of reproduction.

Infection through a miasm, or "miasmatisation," on the contrary, is the communication of a specific poison, having the power of reproduction in the soil, and totally independent of living man. A distinction is drawn between terrestrial and atmospherical miasmata: the former are three in number, viz., the emanations which produce intermittent fever, yellow fever, and Indian cholera. There is one miasm which is looked upon as atmospheric, namely, that which is supposed to produce influenza. In drawing a distinction between contagion and miasm, Dr. Mühry makes the following figurative illustration:—"A miasm, for example that of cholera, is like the giant Antæus, who was said to be the son of Gæa and Neptune, and who was so difficult to be subdued, because on touching his mother earth he acquired new strength. Contagions, on the other hand, are the children of men who assail their own parents, and flourish at their expense."

Following up our author's symbolization, we may remark, as touching cholera, that although we cannot expect to see it so completely vanquished as Antæus was by Hercules, still we are persuaded that the promulgation of wise sanitary laws and regulations can do much towards robbing it of its terrors. Dr. M. then goes on to state, that the operation of a miasm resembles that of an ordinary poison in the absence of an incubation period, whereas contagion never acts without a regular term of *fermentation*, the so called incubation stage. Considered in a geographical point of view, some contagious diseases are ubiquitous, for example small-pox, measles, and scarlet fever, and to these is added hooping-cough; they are quite independent of telluric conditions, of temperature and season, and are being perpetually renewed, and constantly seeking new victims. Indeed the greater number of contagious diseases are ubiquitous, that is to say, they are uninfluenced by soil and temperature, such as mumps, puerperal fever, erysipelas, hospital gangrene, pustule maligne, &c., &c.

There are certain contagious diseases, however, which fortunately do not possess this attribute, but are confined within certain geographical limits, and which are determined by the temperature alone, uninfluenced by the condition of the soil.

With respect to the plague, Dr. Mühry is of opinion that it is decidedly contagious, although evidently dependent to a great degree upon temperature. There are circumstances connected with the appearance of the plague which are calculated to lead to the belief that it depends upon miasmatic causes, but a survey of all the bearings of the subject proves that it is quite independent of the telluric influences. As likely to mislead, is the fact, that the epidemic spread of the disease in Upper Egypt is coincident with the termination of the overflowing of the Nile. The approach of the cool weather seems, however, to have more to do with it than the condition of the soil; with the approach of summer the plague disappears.

In Cairo the thermometer stands at 13° R. in November, 11° in January, 10° in February, 14° in March, 26 in April, 20° in May, 22° in June, 23° in July, 24° in August, 20° in September, in October 17°. The overflow of the Nile begins at the end of June, the water attains its highest point in September, and the termination is in November. When the plague appears in an epidemic form it is in November we meet with it; in summer only a very few and isolated cases occur.

Commencing, then, with the cool weather of winter, it attains its maximum of intensity in the first month of the year, diminishing after April, and finally disappearing towards the end of June. In Egypt, and in other localities, an epidemic continues from half a year to three years; it does not reappear until a lapse, at least, of five years, and generally after a much longer period (the last great epidemic was in 1835).

The slimy state of the soil continues but a very short time after the overflow of the Nile, the land soon becomes dry, and, consequently, malaria fever is on the whole rare in Egypt.

The absence of the plague in the south of Upper Egypt is remarkable, although the like conditions with regard to the Nile prevail, but here the temperature is over 20° R. In countries in which neither overflow nor moisture prevails, the plague may be epidemic, but high ranges of temperature prevent it here also. In Syria, in Asia Minor, and on the coasts of the Black Sea, the plague does not prevail in the hot summer months. The contagion of plague has been operative in Constantinople in winter, and in Northern Europe at the breaking up of the frost. In England it has prevailed from June to November. It has also existed when frost was present, and even in Iceland it has appeared, but only in the summer. That the plague, so dependent on temperature, does not proceed from miasms is evident. In 1813, and in 1841, it was imported into Malta, the soil of which is not suitable to miasms, being calcareous, and the climate dry. Constantinople, in which the plague is so frequently present, is not built upon any peculiarly miasmatic soil; and Marseilles possesses a dry soil. On the contagion of plague, Dr. Mühry quotes our distinguished countryman, Mead, who he says was well acquainted with it. Mead likened the plague contagion to that of small-pox, but the latter recognizes no such influence as temperature; it prevails alike "in summer's heat and winter's snow," while the plague poison, even when imported, requires a certain range of temperature, viz., between the freezing point and 21° R. The boundaries of the plague may be thus stated:—

Towards the South of the Isothermal line of 21° R.; towards the East it never oversteps Persia, its line of demarcation being between the Persian Gulf and the Caspian Sea; in the West the Atlantic Ocean, and in the North about the Isothermal line of 0° R. Dr. Mühry thinks the longer period of incubation of the plague poison, and the fact that as a rule it only attacks an individual once, with few exceptions—of 4,400 cases only 28—distinguishes it from the miasmatic, and that these two peculiarities prove that the disease is the result, not of the mere absorption of the poison, but of the fermentative process. The incubation period of plague has excited much interest both in a sanitary and commercial point of view. It seems to be determined by the investigations of M. Aubert Roche, to which the Academy have affixed the seal of their approval, that the incubation stage of plague does not exceed eight days. "En dehors des foyers épidémiques, la peste ne s'est jamais déclarée, chez les personnes compromisès, plus de huit jours apres un isolement parfait."

One of the most convincing proofs that the plague is not generated in the soil and transportable by the wind is derived from the effects of the sanitary regulations. It has disappeared from Asia Minor and Syria. Since 1841 there has not been a case of plague in Constantinople, and in the whole kingdom there has not been a single case for six years. In Egypt there has not been a severe epidemic since the year 1835.

There are still some points connected with the plague undetermined; for example, the period in the disease when contagion is most effective, and whether it be capable of clinging to substances, and how long it can continue in the air.

It is, moreover, doubtful, whether Europe owes its more than a century's immunity to the quarantine and sanitary regulations enforced in the harbours of the Mediterranean and on the borders of the Turkish Empire, or to an alteration in the atmospheric constitution of the period.

To the latter, as by far the more probable cause, he would incline. The duration of quarantine has of late years been greatly diminished, and most properly so with respect to the disease under discussion, if the incubation stage does not exceed eight days, for the belief in which there appears to be conclusive evidence.

We reserve, for a future Number, a consideration of Dr. Mühry's remarks on typhus.

Extract from a Valedictory Address to the newly made Medical Graduates of the University of Edinburgh, 1*st August*, 1855. By Professor Simpson.

Gentlemen,—It falls this year to my lot to address to you a few farewell remarks, on the part of my professional brethren and myself, before we now separate—and separate for ever—as professors and pupils. These remarks, however, will be brief; as I know your impatience to be set free from this, the last and only remaining link in the chain of academic restraint. For, though it be true that the absolute shortness of human life is a constant and common theme of regret, yet it is equally true, that all of us anxiously press and hasten from one step and stage of human existence, upward and onward to the next, sorely begrudging, in this railway race of existence, all detentions and delays. You are to-day arrived at what is, perhaps the most important station in this journey, for you have now reached, and are about to cross, the great boundary line between the light academic life of the young student, and the hard practical life of actual manhood. Ere you pass this line, however, allow me, in right of my office as your promoter, to stand athwart your path for a few minutes, and speak of the prospects and the obligations which await you on its further side, as medical practitioners.

And, first, let me venture to warn you, in all kindliness of spirit, that the bright and brilliant hopes which some, which perhaps most of you, entertain of rapid and almost immediate success in medical life, are, I fear, doomed to certain failure. I speak specially of the Graduates among you, who are about to engage in civil practice; and these constitute a vast majority of your number. For the painful trammels and degrading neglect, to which medical officers in the public services of the British army and navy are still so discreditably subjected, are such as debar and deter men of ability and independent spirit from permanently joining their ranks. Besides, even the very highest grades of the public medical service are scarcely in themselves objects of honourable ambition. The gentleman who is at this moment at the head of the medical department of our great army in the East—a physician, I believe, of high talents and energy, Dr. Hall—undergoes all the enormous responsibilities and work of that office, and all the enormous abuse and obloquy too, connected with the discharge of it, for a salary of two guineas a day—an income far less than that made by many a second or third rate village apothecary in England. Most of you, I repeat, are destined for civil practice; and again I warn you, that, as the general rule, such practice rarely or never comes speedily, in a pecuniary form, to the young physician, however high his aspirations, and however great his talents may be. The same fact holds true of most other professions, and trades; but it holds, and has ever held, especially true of medicine. We have little or nothing on record to unfold to us the secret history of the early struggles, trials, and difficulties of medical practitioners, except in the published biographies of a few of those men, whose supreme talents have ultimately carried them to the very foremost rank in their profession. The history of these princes and chiefs of the medical art is in every known instance, I believe, an illustration of what I allude to,—the slowness and difficulty with which practice, or at least remunerative practice, gathers around the door of the young physician, especially in our larger communities and cities. A former graduate of this University, Dr. John Cheyne, who, a quarter of a century ago, was by far the busiest, and best employed physician in Dublin, tells us in his interesting autobiography, that during the first half of his second year's settlement in the Irish capital, and when he had already reached the thirty-fourth year of his age (an age which it will be long before some of you yet attain), his fees only amounted to about three guineas. Nine years subsequently, he was making £5000 annually. Not above one or two physicians in London ever drew, I believe, a larger professional income, or perhaps ever advanced more early into full practice than Dr. Chambers; yet, during the fifth year of his practice, when he was already thirty-four or thirty-five years of age, he did not receive above £211 in fees. Seventeen years subsequently, his annual professional income is stated to have reached nearly to £9000. His great predecessor in high London practice, Dr. Matthew Baillie, drew above £11,000 in one year; and yet with all the interest of the Hunters and others, to aid him in his outset, his first march upwards was, like that of all others, very slow and difficult, and to quote the words of his biographer, Dr. Wardrop, before "he found himself fairly established in practice," he had been already for twelve years physician to St. George's Hospital, and for nearly twenty years a medical lecturer. Dr Baillie's uncle, the celebrated Dr. William Hunter, who spent a large fortune, gained by his profession alone, upon the collection of that splendid museum which now enriches the University of Glasgow, was so hard-pressed for money during the years of his earlier struggles in London practice, that he was obliged to postpone for a fortnight, the commencement of his third season of lectures, in consequence of not having money enough to pay the expense of the usual class advertisements. Nor have our greatest surgeons been usually more successful than these our greatest physicians, in the first stages of their professional career. In 1788, the son of an English clergyman attended the medical classes of this University, and lived on the third flat in Bristo-street, in a room which cost him six shillings and sixpence a week. In after life, when swaying the surgical sceptre of England, as Sir Astley Cooper, his professional income, in one single year, amounted to £23,000; and yet, during the first twelvemonths after he settled down in London, and was working as a lecturer on anatomy and surgery, his receipts from private practice only amounted to five guineas. The distinguished surgeon, who, by Sir Astley's death, was left at the head of the surgical school of London, Sir Benjamin Brodie, did not, as we are told, in a late biographical sketch of him, get into "full practice" till 1825; yet he had been lecturing, practising, and publishing since 1805, or for twenty long years previously. "I well remember," observes Sir Benjamin, in one of his published works, and when speaking of the early struggles and disappointments of young medical practitioners, "I well remember, in relation to myself, how often, in the intervals of occupations, I have contemplated, with something like dismay, the prospect which lay before me." And I believe almost all medical men have had occasion, in early professional life, to participate more or less deeply in that feeling. All my medical colleagues around me will probably, like myself, be ready to subscribe to the truth of the observation, in their own individual instance. No doubt, also, fate holds in store a similar destiny for you. And, if a period of probation and trial is thus ready to meet you at the outset of professional life, be you also ready, with brave and stout hearts, to meet it.

This impending period, however, of watching and probation, cannot and dare not be with you a period of rest and idleness. On the contrary—if you do not wish to sink even below mediocrity—your pursuit of medical knowledge, during this period, must be increased instead of diminished, redoubled instead of slackened. It must be, in truth, a term of fresh and fervent professional study—of earnest and manful professional work. For during it, you have to confirm and correct, and—still more—to extend and enlarge your present stock of information, on a thousand different points, and in a thousand different directions.—*Edinburgh Med. Journal.*

EAST INDIA ASSISTANT SURGEONS.

RETURN *to an Order of the Honourable the House of Commons, dated* 10*th August*, 1855; *for*, A COPY *of the Report, dated the* 24*th day of July*, 1855, *sent to the Commissioners for the Affairs of India by the Examiners appointed under the Act of the* 16*th and* 17*th Vict.*, c. 95, *for the Examination of Candidates for the Appointment of Assistant Surgeon in the Service of the East India Company.*

India Board, 10*th August*, 1855. T. N. REDINGTON.

The EXAMINERS to the PRESIDENT of the BOARD of CONTROL.

24, *Henrietta-street, Cavendish-square,*
24th July, 1855.

SIR,—We have the honour to inform you of the completion and result of the examination of candidates for Assistant Surgeoncies in the Honourable East India Company's Service. The examination was conducted on the same plan as the last. Each of the candidates was submitted to the following tests: namely, an examination in writing in each of the four appointed subjects—Medicine, Surgery, Anatomy and Physiology, and Natural History; an examination, *vivâ voce*, for one hour in the same subjects; an examination for an hour in the investigation of a Medical and a Surgical case; and an examination for the same time in operations on the dead body, and in the application of surgical apparatus. By the method thus adopted, each candidate was under examination for fifteen hours.

We beg to submit, in order of merit, the names of 42 candidates, selected from 55 who presented themselves for examination. The gentlemen included in this list are fully qualified to receive appointments.

We beg also to append copies of the questions proposed in the written examinations.

William Walker, M.D., M.R.C.S.Ed.; Charles Brettingham, M.R.C.S.E.; George A. Watson, M.R.C.S.E.; Bernard Kendall, M.R.C.S.E.; J. L. Stewart, M.D., Glasgow; Theobald Matthew, M.B., M.R.C.S.I.; Jas. Fairweather, M.D., M.R.C.S.Ed.; Boon Hayes, M.D., M.R.C.S.E.; David Hood, M.D., M.R.C.S.E.; Charles J. Jackson, M.R.C.S.E.; John Kirk, M.D., M.R.C.S.Ed.; Robert Bird, M.D., M.R.C.S.Ed.; A. A. Duncan, M.B., M.R.C.S.I.; J. Martin Coates, M.F.P. and S.G.; Henry Thom, M.D., M.R.C.S.E.; Francis Sillifant, M.R.C.S.E.; John T. Penhall, M.R.C.S.E.; Daniel M'Auley, M.R.C.S.Ed.; Charles A. Poole, M.R.C.S.E.; Charles Plank, M.R.C.S.E.; — Equal: Frederick Carter, M.R.C.S.E.; William H. Hayes, M.R.C.S.E.;— Francis H. Plumtre, M.R.C.S.E.; Thomas Croudace, M.R.C.S.E.; George E. Seward, M.D.Ed.; Henry Griesback, M.R.C.S.E.; Benjamin Hook, M.R.C.S.E.; Andrew Thomson, M.D., M.R.C.S.Ed.; Henry King, M.B., T.C.D.; C. Gordon Asher, M.D., M.R.C.S.Ed.; Robert

Dempster, M.R.C.S.E.; John Pinkerton, M.R.C.S.Ed.; William H. Bourne, M.R.C.S.I.; Richard Boxwell, M.B., M.R.C.S.I.; Frederick K. Hammond, M.R.C.S.I.; John Houston, M.D.Gl., M.R.C.S.Ed.; Henry E. Busteed, M.R.C.S.; Henry Crocker, M.D., M.R.C.S.Ed.; C. F. Wheatley, M.F.P. and S.G.; Richard Arnold, M.R.C.S.E.; Hunter Adam, M.R.C.S.Ed.; William H. Morgan, M.R.C.S.E.

We have, &c.
(Signed) George Busk.
Joseph D. Hooker, M.D.
James Paget.
W. H. Walshe, M.D.

The Right Hon. R. Vernon Smith, M.P.

NATURAL HISTORY.

Monday, 16th July, 1855.—10 to 1 o'clock.

Dr. Hooker.

Botany.

Answer any five or more of the following Questions:

1. Give examples of medicinal plants in the natural order Umbelliferæ.
2. Define a Rhizome, a Corm, a Tuber, and a Bulb.
3. What are the properties of Ranunculaceæ? and give examples.
4. What are the most conspicuous botanical characters of the natural order Papaveraceæ?
5. Define the terms Thalamifloral, Calycifloral, and Corollifloral.
6. Describe the structure of the fruit in the Apple, Strawberry, Raspberry, and Peach.
7. What are the chief botanical peculiarities of Cruciferæ, and in what parts of the plant do their properties reside?
8. Distinguish Melanthaceæ from Liliaceæ.
9. Describe the germination of flowering plants (Monocotyledonous and Dicotyledonous).
10. What are the chemical changes undergone during the process of germination?
11. Describe the process of respiration by the leaves of plants.
12. Describe the process of impregnation in Coniferæ.
13. What is the principal cause of the motion of the sap in flowering plants?
14. Why is sap-wood less durable than heartwood?
15. Describe the fruit and seed of the castor-oil plant.
16. In what parts of Umbelliferæ do the essential oils chiefly reside?
17. What are three principal modes of placentation?
18. What is Endosmosis?
19. What are the chief products of the cocoa-nut tree, used in the arts, &c.?
20. How is starch converted into sugar in the vegetable economy?
21. What does a grain of wheat (commonly so called) consist of?
22. State the names and relative positions of the parts of a papilionaceous flower.
23. What are the principal nitrogenous products of plants, and what the non-nitrogenous; and how do they severally contribute to the food of animals?
24. What are De Candolle's principal divisions of Dicotyledonous plants, and what are their characters?

Comparative Anatomy and Zoology.

Answer any three or more of the following Questions:

1. Enumerate the principal groups of the molluscous sub-kingdom, giving an instance of each.
2. Describe the general plan upon which the circulation is carried on in fishes and reptiles respectively, and mention any general circumstances in which the circulatory apparatus in the classes below the vertebrata differs from that which exists in that division.
3. What are the distinctive characters of the principal classes of the articulata?
4. To what orders do most of the hybernating animals belong? Give examples; and describe the condition of their functions during hybernation.
5. Describe the origin and formation of the silk of the silk-worm, of the spider's web, and of the material used by wasps and their allies in the construction of their nests.
6. Enumerate the orders of insects, their characters and metamorphoses.
7. Give a general comparative view of the nervous system in the sub-kingdoms of animalia.
8. Enumerate the bones in the fore and hind legs of the horse, and compare them with the homologous organs in man.
9. Compare the wings of a bird, bat, flying squirrel, and pterodactyle.
10. Give instances of real or supposed hybrid animals; mention any laws that appear to control their production, and any peculiarities (structural or functional) which hybrids usually possess.

SURGERY.

Monday, 16th July, 1855.—2 to 5 o'Clock.

Mr. Paget.

1. What are the chief conditions from which secondary hæmorrhage may ensue after an operation (say, after amputation below the knee); and what are, in each case, the best means of treatment?
2. If hospital-gangrene were prevalent in an hospital under your charge, and you were unable to remove the patients, what would you do?
3. In what conditions due to injury, or to disease of the bones of the skull, would you think it proper to remove portions of those bones, with the trephine or other instruments?
4. Make lists of the instruments, &c., that

you would require for each of the following operations: viz., amputation below the knee, ligature of the femoral artery, and tracheotomy.

5. State the usual direct and remote consequences of fracture of the spine, with crushing of the spinal cord, in the lower part of the cervical region, and explain them physiologically. What are the chief differences between the symptoms of this injury, and those of a similar injury in the lumbar region? And what the chief things to be attended to in their management?

6. What are the conditions under which swellings not aneurismal are attended with pulsation? and how may such swellings be, generally, distinguished from aneurisms?

7. Describe the process for the separation of a slough of the integument; and that for the healing of the surface exposed by its removal.

8. J. S., aged 14, was struck sharply on the lower part of the right tibia, and for twelve months following the blow, suffered almost constant, and often very severe, pain in the part. Ten months after the injury, an incision was made down to the painful part of the bone, in the belief that acute periostitis existed; but the operation gave little, and only temporary relief. Various other treatment was employed without any advantage, and, at the end of twelve months, the pain was in no degree diminished; it was a constant aching, with frequent paroxysms of great severity. The lower end of the tibia was now uniformly enlarged to about one-half more than its natural size: the enlargement gradually diminished up the shaft, and did not extend above its lower fourth. The surface of the enlargement felt everywhere bony. On every part of it even moderate pressure produced severe pain. There was general, but not great, swelling about the ankle-joint; and its movements were limited, but painless and without grating. The constitutional disturbance was only such as might be ascribed to long-endured pain.

What was the disease in this case? and what the appropriate treatment?

MEDICINE.

Tuesday, 17th July, 1855.—2 to 5 o'Clock.

Dr. Walshe.

1. What are the influences severally exercised by heat, solar and artificial,—moisture, moderate and extreme in amount,—wind,—vegetation on the surface of stagnant water,—and elevation of locality, on the diffusion and activity of marsh-malaria?

2. Give the anatomical characters of acute and chronic cerebral meningitis.

3. Describe the "simple chronic" or "perforating" ulcer of the stomach. How is perforation of this kind to be distinguished (on anatomical grounds alone) from destruction of the coats by cancerous ulceration, by post-mortem action of the gastric juice, and by sulphuric acid?

3. State the symptoms and treatment of a case of acute sthenic dysentery in a previously healthy adult, inhabiting a temperate climate.

5. An adult male presents the following physical signs:—*On Inspection:* arching of the præcordial region, with slight bulging of its intercostal spaces; undulating impulse; elevation of the heart's apex-beat to the fourth interspace. *On Palpation:* feeble, unequal fluttering impulse. *On Percussion:* dulness over a triangular space, the apex of the triangle reaching the first left costal cartilage, the base coasting the sixth rib. *On Auscultation:* feebleness and apparent distance from the surface of the heart's sounds inferiorly; relative clearness of both at the top of the sternum; friction-sound of cardiac rhythm faintly caught in some postures of the patient; no endocardial nor aortic murmur.

Show how these signs fail to establish the diagnosis of either hypertrophy of the heart, flabby dilatation of that organ, aneurism of the arch of the aorta, or hydro-pericardium; and how, on the contrary, they prove the existence of pericarditis with effusion.

6. What are the distinctive marks between a simple ovarian cyst, a large fibrous tumour of the uterus, and ascites?

7. What are the physical signs and symptoms of copious acute pleuritic effusion? Supposing a patient with such effusion to be a well-constituted and previously healthy male adult; the disease to have reached, say, from the sixth to the ninth day, and no treatment of any kind to have been yet employed, how would you manage the case?

8. Give an outline of the physiological and therapeutical effects of strychnia, indicating the doses from which the effects described are to be expected in the adult human subject. Are the same effects produced by brucia?

9. An individual, labouring under the uric acid diathesis, takes benzoic acid in free quantity; what ensues, and how is the result explicable?

10. Mention the ordinary adulterations or accidental impurities, and the means of detecting them, of iodide of potassium.

11. Write prescriptions in Latin, without using abbreviations, for—(*a*) gallic acid in a severe attack of hæmoptysis; (*b*) liquor potassæ arsenitis in an old-standing case of lepra vulgaris. The patient is supposed in each instance to be an adult.

ANATOMY AND PHYSIOLOGY.

Tuesday, 17th July, 1855.—10 to 1 o'Clock.

Mr. Busk.

1. Describe the occipital bone, its articulations with other bones; the points of attachment

of the various muscles affixed to it, and the mode in which its ossification takes place.

2. Enumerate the muscles of the back of the trunk, and the order in which they occur in dissection.

3. Describe the surgical anatomy of the subclavian artery, and indicate the part most eligible for its ligature in case of aneurism below the clavicle, with the steps of the operation.

4. Describe the parts concerned in femoral hernia, and point out the anatomical conditions distinctive of that form of hernia.

5. Give the distinctive physical and chemical characters of yellow elastic tissue, and notice the principal situations in which it occurs in the human body.

6. Describe the structure of a nervous ganglion.

7. Mention the principal heads under which alimentary substances may be arranged, and give one or more instances of substances belonging to each group.

8. Describe the changes undergone by the chyle in its passage from the intestine into the blood.

9. What is the cause of the suffocation which usually supervenes upon division of the inferior laryngeal nerves, or of the trunk of the pneumogastric nerve above those branches? and state what muscles of the larynx are supplied with motor power by the superior laryngeal nerve.

10. What circumstances increase or diminish the amount of carbonic acid exhaled by animals?

The next Examination will take place in January, 1856, and it is expected that about twenty-five appointments will be made. A copy of the regulations, and of a statement respecting the examination in Natural History, may be obtained on application to the Secretary of the Military Department, at the India House.

SELECTIONS FROM BRITISH AND FOREIGN JOURNALS, &c.

On the Nature of the Cerebral Symptoms occurring in Albuminuria. By M. Marchal (Calvi).

The object of this communication (in the *Gazette des Hôpitaux*) is to show that these symptoms are the result of serous effusion either into the arachnoid sac, or into the subarachnoid cellular network, and not of uræmia, as has been supposed by *Frerichs* and many others. Hence, the author is of opinion, that there is much danger in the use of hot or of vapour baths in albuminous anasarca. He thus states what he calls "*his* doctrine":—"When the albumen of the blood is escaping with the urine, whether in cases of pregnancy, or as the result of a chill to the surface, or after one of the exanthemata, especially scarlatina, or lastly, as in 'granular disease' of the kidney, the serum is apt to exude from the capillary vessels, the albumen being the bond of union between it and the rest of the blood; hence, dropsies arise. Under these circumstances, if owing to any exciting cause, as a vapour bath, for example, or independently of this, owing to some idiosyncracy, there be a determination of blood to the head, there will then be produced 'cerebral symptoms' of the convulsive, or comato-convulsive class."

The following case is given in illustration:—

Case 1.—A *gendarme*, of robust health, with the exception of being slightly rheumatic, became suddenly chilled after having been in a perspiration. Next day he was admitted into the *Val de Grâce*, labouring under general anasarca; the urine was excessively albuminous; after being purged he seemed to be better. For the two next days, in accordance with the general advice of authors, he was given a vapour bath, when he was attacked with pain in the head, then with epileptic fits; in the ninth of which he died.

Autopsy.—There was extreme hyperæmia of the kidneys, and pus was found in the parenchyma of the organ and in the pelvis. The brain was excessively congested, and there also existed serous infiltration of the subarachnoid cellular tissue.

A second example is then given, to illustrate further the danger of hot baths in such cases:—

Case 2 was that of a young lady who was affected with albuminous anasarca during her pregnancy. She was very anæmic, and greatly enfeebled. At three months she miscarried. When consulted, M. Marchal examined the heart, it was healthy; the urine was albuminous, but only slightly so. He considered the dropsy was now chiefly owing to the extreme debility of the patient, and ordered iron, &c., whilst albuminous drinks, sweetened with sugar and eggs, were given to try and repair the loss of albumen in the blood. The patient was better, and had been able to go out to drive, when the ordinary medical attendant thought of giving baths to remove the dropsical effusions. The patient took three baths. Each time her face was a good deal flushed; after the third she suddenly lost her sight, and her speech became difficult, though her mind was unaffected. In a few days she died. There was no examination of the body.

Remarkable Case of Subclavian Aneurism; New Method of Treatment; Recovery.

Mr. Fergusson presented to his class, at the King's College Hospital, on the 4th of August, a most interesting case—one of a series, as we subsequently learned—where a very remarkable cure has been effected in well-marked subclavian aneurism, by a new and specific method of manipulation which he has adopted. We may state here that we saw the case about a year and a half ago also, when the man was previously under treatment. Some short period before that time Mr. Fergusson conceived the plan of stopping the circulation in the aneurism by pressing the sides of the aneurismal sac together, with their intervening fibrinous deposit; and in this case, from the phenomena attending the manipulation, there appeared to us very little doubt that the object held in view by Mr. Fergusson had been attained—viz., the clots of fibrin in layers in the aneurismal sac had been displaced, and, spreading from the subclavian into the axillary and brachial, a new sort of Brasdor's operation, at the distal side of the subclavian, had been the result. In other words, we believe Mr. Fergusson here without ligature had attained all the advantages of the last-named operative proceeding; for not only had a blocking-up of the axillary and brachial been followed by a partial stoppage of the current through the enlarged aneurism of the subclavian, but even with very marked, but not so satisfactory, results as regarded the pulse in the radial at the wrist, which became completely stopped for a time, with symptoms of paralysis in the arm, all resulting from the displacement of the fibrinous clots.

The aneurism in the present case was situated in the subclavian, in the usual site of subclavian aneurism—namely, between the scaleni muscles, and to us seemed almost to invite some modification of the Dublin surgeons' plan by compression on the first rib. The plan by compression, we need hardly observe, is in general applied to the artery above the aneurism, between the latter and the heart. Crampton, however, in 1816, showed that the obliteration of an artery can be effected without rupture or ligature of its coats, as generally conceived, simply by this blocking-up process. The early volumes of *The Lancet* contain cases also cured by Brasdor's operation; it seems, however, more applicable to carotid than subclavian aneurism.

Mr. Fergusson related to his class on the 11th, at some length, the details of a previous case of subclavian aneurism, of the same character as the present, in which his ideas on this subject were first matured. In both cases the method of cure by deligation at the tracheal side of the scaleni, as well as Brasdor's operation at the distal end of the aneurism, were inadmissible; yet it was gratifying to find the present plan, by firm pressure of the thumb on the aneurism, so as to displace some of the fibrinous clots, followed up by local pressure, succeeded in obtaining most striking and in many respects curious but satisfactory results. In Mr. Fergusson's new mode of operation, we believe an entirely novel idea is acted on—namely, the displacement of the lamellated fibrin of the aneurism, on which no operation has been performed, and so directing the clots of fibrin that they shall block up the distal end of the artery so diseased. As Mr. Fergusson has expressed an intention of bringing the entire subject under the notice of the Medico-Chirurgical Society, we purposely abstain from giving the cases in detail. The method of treating aneurism by compression, originating with Desault and Hunter, and recently revived with such excellent results by the Dublin surgeons, will gain an immense accession of interest, if it should prove that the fibrinous deposit of the sac of the aneurism may be thus as it were utilized in bringing about the results hitherto gained in a different mode by Brasdor's operation at the distal end of the aneurism. Considerable caution will be at first necessary, as observed by Mr. Fergusson, in selecting cases which are fitted for the present method, as premature or ill-judged experiments, in the shape of direct pressure or manipulation on the sac of aneurism not requiring it, would be certain to be followed by severe inflammation of the sac and other dangerous results. The spontaneous cure of aneurism is not unknown in practice; it may take place, it must not be forgotten, by a coagulation of the contents or increase of the quantity of lamellated blood in the sac, the cavity becoming filled, and the circulation conveyed to the parts beyond the disease by the collateral vessels; or, again, in some rare cases the aneurismal tumour may be doubled up and press upon the portion of artery leading directly to the aneurism; or in a third fashion, as in a remarkable case given by Mr. Liston, where the patient had well-marked subclavian aneurism, which subsided and disappeared—an aneurism of the innominata pressing on and obliterating the aneurism of the subclavian!

Whatever may prove to be the correct pathological explanation of the phenomena in Mr. Fergusson's present cases, we deem it our duty to state here briefly that the cure seems complete and unequivocal without any ligature of vessels, nor is there any reason to believe the case was one of spontaneous cure of subclavian aneurism, as in the case given by Mr. Liston. It is now two years since the man came first under observation; he has been, on and off, under treatment all that time in King's College Hospital and at home in the country; but happening to be in town within the last fortnight, Mr. Fergusson took advantage of the opportunity to exhibit the case to his class.—*Lancet.*

M. REMAK *on the Motor Functions of the Great Sympathetic Nerve. Communicated by* CLAUDE BERNARD.

We have learned by the discoveries of Petit, in 1712, and of Claude Bernard, in 1849, two motor functions of the cervical portion of the sympathetic, one upon the dilator muscles of the pupil, the other on the blood-vessels. A third motor effect on the muscles of the eyelids is added by Remak.

In the cat or dog the division of the sympathetic nerve in the neck is immediately followed by considerable narrowing of the aperture of the eyelids.

When the peripheral portion of the nerve is excited by a current of electricity, the upper lid is strongly elevated, although the animal endeavours to close the eyes by the spasmodic contraction of the orbicular muscles. On stopping the current, the eyelid again descends. The same results always are observed on repeating the experiment at short intervals.

In the sheep the same phenomena are observed, but not so remarkably as in the cat or dog.

In the frog, electrical excitement of the sympathetic does not affect the eyelid or the pupil, but section of the nerve is attended by contraction of the iris.

It thus appears that the sympathetic is capable of influencing the voluntary muscles.

Remarks on the Influence of the Circulation on the Movements of the Iris and other Contractile Parts. By M. A. Kussmaul, Heidelberg. *Communicated by* M. Claude Bernard *to the Academie des Sciences.*

The essay is the result of upwards of sixty experiments made on different animals, consisting in compressing or tying the different arteries or veins of the neck, so as to produce, at different times, arterial anæmia or hyperæmia, venous congestion or the reverse. The conclusions he arrived at are the following:—

1. and 2. That the circulation of the blood exercises an influence, subject to certain laws, on contractile parts of the head.

3. The phenomena are not produced, unless considerable disturbance of the circulation is effected.

4. An arrest of the arterial blood going to the head, produces at first contraction of the pupil, of the eyelids, of the nostrils and mouth, and of the aural orifice. Subsequently these parts enlarge. Of these phenomena, the contractions of the pupil and of the eyelids are constant, the others are variable.

5. A subsequent reflux of arterial blood produces marked dilatation of the pupil, of the eyelids, and of the aural orifice. The mouth rarely is altered, the nostrils are uncertainly affected; the circulation once established, their openings resume their original diameters.

6. The retention of blood in the veins of the head produces sometimes contraction of the pupils; motions of the globes of the eye were also observed under these circumstances. When venous congestion was produced, the eyeball became advanced, and retired again when the blood was allowed to pass on towards the heart. When the arterial blood was evacuated, the same phenomena were observed as when its circulation towards the head was arrested.

Bernard's *Theory of the Glucogenic Function of the Liver, illustrated by the Occurrence of Morbid Changes in the Liver, in Cases of Glucosuria. Communicated to the Academie des Sciences* by M. Andral.

In a recent Number of the Dublin Hospital Gazette (No. 13, page 202,) we gave an account of the report of the French Academy upon Claude Bernard's theory of the glucogenic function of the liver. The question is still far from being finally settled, and many physiologists refuse to acquiesce in the modern view. At a recent meeting of the *Academie des Sciences*, M. Andral made an interesting communication, with the view of showing what evidence pathology gives on this subject.

The question has not, hitherto, been considered by any one in its pathological bearings, and as there is no one whose opinion is entitled to command respect more than M. Andral, we consider that his views will be read with interest. Having first alluded to the important results which have followed experiments made upon living animals, and to the facts taught by comparative anatomy, M. Andral says that he thinks "pathology will prove another source of enlightenment to physiology," and he thinks no physiological fact can be regarded as fully established, unless it stands all the tests of experiment, researches in comparative anatomy, and pathology. The present communication is to bring the result of certain pathological observations to bear upon the interesting question of the source of sugar in the animal economy. For this purpose, M. Andral gives the results of some observations made upon diabetic patients:—

1. As to the influence of a diminished amount of food on the quantity of sugar in the urine, it was observed, whenever a patient with saccharine urine ceased, from any cause, to take food, that the sugar in the urine diminished in quantity or disappeared altogether. This statement is supported by the results of many examinations of the urine made for M. Andral by M. Fabre, whose name and works, he adds, are long known to the *Academie*. For example, a female, whose urine was daily analysed, passed every twenty-four hours with this liquid from 40 to 70 grains of sugar in the pint (French measure). Her diet had been liberal, when a gastro-intestinal affection occurred, followed by complete loss of appetite and diarrhœa. The day after her diet had become so much diminished, the urine yielded 54 grains of sugar in the pint; forty-eight hours afterwards it only produced 34 grains; and twenty-hours later only 28 grains. The patient now ceased to take any food (*diète absolue*); after forty-eight hours of complete abstinence the urine no longer contained any sugar.

An improved condition of the digestive organs permitted the patient once more to take some food, however the sugar was not immediately reproduced. It was not until after three days that it was found in the urine; at first there were but 20 grains in the pint, then rapidly the quantity became the same as it had been before the patient's abstinence from food.

Thus, whilst M. Bernard has shown, in his experiments, that the liver and the hepatic veins contain much less sugar when an animal ceases to take food, pathological observations tend to the same result, and show that when food is not taken, sugar no longer appears in the urine, and, hence, we infer it is formed in much smaller quantities in the system.

2. It may be asked, when those substances capable of being transformed (chemically) into sugar are absent, can sugar, nevertheless, be produced in the *organisme* at the expense of the albuminous matters used as food? The experiments of Bernard answer in the affirmative, for he found a considerable quantity of sugar in the liver and hepatic veins of dogs, who for a long time had lived on nothing but animal food. Pathology tends to a similar conclusion, for we learn that although, by withholding from the diet of persons affected with glucosuria every kind of sugary or starchy matter, we may diminish the quantity of sugar in the urine, yet, in the great majority of instances, we cannot make it to disappear altogether; it even occasionally happens that under such circumstances the amount of sugar in the urine may become increased. Several cases attest this. In one diabetic patient, for example, who fed himself on meat alone, he found 82 grains of sugar in the pint of urine, or about 656 grains in the twenty-four hours.

If, as we are to deduce from the experiments of Bernard, sugar is formed in the liver, and if the blood, as it leaves the liver charged with sugar, no longer contains any after it has passed through the lungs, it may be supposed that the sugar found in the urine, in diabetes, is the result of one of two conditions—either of a diseased liver forming a superabundant quantity which escapes the action of the lungs, or some alteration in the lungs themselves which allows the sugar brought by the hepatic blood to pass unaltered. But special changes are not found in the lungs in diabetes, with the exception of tubercles; these certainly do not cause diabetes, for the urine of phthisical persons does not contain sugar.

But whilst nothing special is found in the lungs in diabetes it is not so with the liver. In fact, since Bernard's views were published, M. Andral says that he has seen in five cases abnormal condition of the liver in diabetes. The changes were in all identical, and consisted in a dark red coloration, so remarkable, that the liver, instead of presenting two colours, yellow and red, presented throughout a uniform red colour; in fact, intense hyperæmia. This, Andral says, is an important fact, and if the liver secretes sugar, it is logical to admit that hyperæmia of that organ in diabetic persons is the anatomical sign of that over-activity which occurs in the glucogenic function. Thus, physiology and pathology mutually illustrate each other. In conclusion, says M. Andral, all I pretend at present to advance is, that in diabetes the liver does not present its normal anatomical condition, that the changes found are always the same, and that this fact, taken in connexion with the discovery of the glucogenic function of the liver, may be considered as one of the proofs of its performing this function.—*Gazette Medicale.*

Urethrotomy.

Discussion on Maisonneuve's Operation.—(*Academie de Medicine.*)—M. Leroy D'Etiolles, in continuation, proceeds to examine into the value of the operation of dividing stricture of the urethra *from without*, an operation *devised*, he says, two centuries ago by a Dutch surgeon, Van Sollingen, and revived in France by Lassus, in Sweden by Exstrom, and in England [Scotland rather] by Syme. He admits that, with certain exceptions, he prefers this operation to every other; but to wish to make it the general plan of treatment, as Mr. Syme does, is not good surgery. [Mr. Syme's views are here altogether misrepresented.] M. L. D'Etiolles has twice operated in this manner.

He then speaks of the use of caustic. Boyer, we are told, when asked about this remedy, replied, with his usual *bonhomie*, "Make haste if you are going to use it, or the patient will be well first." [We would rather call this a caustic remark.] M. L. D'Etiolles thinks not only that caustic does not cure a stricture, but that, if used too freely, it will render stricture more difficult to cure. Under two circumstances he admits its applicability: first, to cause absorption, when a stricture is so tortuous as to be impassible to the finest bougie; second, to cause obliteration of the internal opening of fistulæ. Is there, then, no radical cure for fibrous strictures? M. L. D'Etiolles does not absolutely, *ipso facto*, answer the question, but he inclines to this aphorism, that "strictures rebellious to dilatation must be treated like *cicatrices vicieuses* on the surface of the body, and removed *en totalité*; *excision*, in a word, is his recommendation. On this subject he read a memoir before the *Academie*, in June, 1838, and has since then, in several publications, recommended this treatment. Numerous instruments have been devised by him for the purpose, the principle being the same in all. When practicable, a small conductor is employed, and carried on into the bladder, and over this is passed a hollow instrument with a cutting edge, sometimes made obliquely and running on to a point, so as to cut in a spiral manner; in this way a passage is tunnelled through the stricture.

The author says he has often thus succeeded in obtaining a radical cure, and mentions cures which remained well for several years.

We then read, that this method is not new. [How few inventions are new!] It was used by *Ambrose Paré*, who, speaking of it said, "*Je te puis assurer que j'en ai fait de belles cures.*"

In 1812, James Arnold thus operated with success, in a case of retention of urine from stricture. In 1832, Benjamin Phillips was struck with the advantages of this operation, and recommended it in his work, entitled, "Treatise on the Urethra."

[We have thus given, at some length, the views of some of the French school upon various operative proceedings in cases of stricture of the urethra. Three modes of treatment, it will be observed, have been under discussion:—

1. Urethrotomy, by section *from within outwards*, originally performed by Stafford, Reybard, Heurteloup, &c., and brought recently under notice, in a modified form, as a new operation, by Maisonneuve.

2. Urethrotomy, by section from *without inwards*, as introduced into practice by Syme, but, according to M. Leroy D'Etiolles, originally performed by Van Sollingen. Of this operation, French surgeons do not seem to have had much practical experience. It is favourably mentioned by Leroy D'Etiolles only, who seems to have performed it on but two occasions.

3. The method by *excision*, proposed by Leroy D'Etiolles, and described in the preceding pages. As journalists, we have thus endeavoured to discharge the duty of reporting faithfully the progress of science, but we are constrained to add, that we think the French school might be better employed than in reviving old and exploded modes of treatment. We now speak more particularly of the mode of treatment suggested by M. Leroy D'Etiolles, and which he terms Excision. The argument is, no doubt, a good one, that as excision alone cures fibrous contractions on the surface, it should constitute the treatment of similar conditions in other parts when practicable. But the operation thus named by M. Leroy D'Etiolles is not excision at all: by his method a slice is cut off the mucous surface of the urethra at the narrowed portion; but we need scarcely add, that the greater portion of the diseased part is untouched, as the seat of stricture is not in the mucous membrane, but in the submucous tissue. The term excision is, therefore, in this instance, wholly inapplicable. We can well imagine a case likely to be benefited by Stafford's operation, for we have seen several such; or by that so strongly recommended by Mr. Syme, for there is very strong testimony in its favour; but we cannot imagine any case, in which the so-called method of excision could be advantageously employed.—EDS. DUB. HOSP. GAZETTE.]

Subacetate of Lead in Hypertrophy of the Heart.

M. Braschet (of Lyons), in a communication to the *Academie de Medicine*, says he has for thirty years been employing this remedy with much success in cases of aneurism and of hypertrophy of the heart. Sometimes the benefit is but transient; sometimes it fails to give any relief, especially in disease of long standing. In recent cases its success is undoubted. He employs the remedy in rather large doses, and combined with extract of digitalis:—sub-acetate of lead two parts, extract of digitalis one part, made into pills. The dose to be increased by one pill every fifth day, up to three pills night and morning.

M. Braschet supposes the medicine may act either by causing an astringent effect on the tissues, which may assist the capillary circulation, and so promote the absorption of the hypertrophied elements, or by exercising some special action directly on the heart itself, as *worrara* acts on the nervous system, mercury on the salivary glands, diuretics on the kidney, &c. In young subjects its beneficial effects are most certain.

In the discussion which followed, M. Robert said he recollected acetate of lead to have been frequently used by Dupuytren in cases of aneurism of the aorta, but without success.

[When employed along with digitalis, it is not very logical to infer that all the benefit which may result, if any, is attributable to the one remedy alone.]

Sulphite of Soda in Mercurial Stomatitis.

M. Colomiès (of Toulouse) recommends the internal use of sulphite of soda to counteract the effects of mercurial stomatatis; he bases this therapeutical indication upon the chemical action which the sulphites exert upon mercurial compounds. According to the author, whilst employing this remedy, the mercurial treatment may be continued, even when salivation has already been produced.

DUBLIN: PUBLISHED BY W. B. KELLY,
8, GRAFTON-STREET.
LONDON: S. HIGHLEY, 32, FLEET-STREET.
EDINBURGH: MACLACHLAN & STEWART.
September 15, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.

SENT FREE BY POST.

Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 17.—Vol. II. OCTOBER 1, 1855. Price 5d.

Clinical Lectures on the Diagnosis of Cancer and Cancroid Growths.

BY MAURICE H. COLLIS, M.B., F.R.C.S.I.,

SURGEON TO THE MEATH HOSPITAL AND CO. DUBLIN INFIRMARY, ETC.

LECTURE II.

We shall now proceed to consider the clinical features, to which the deposit of this cancer cell gives rise. They are varied considerably by the age of the patient, by the locality of the growth, and, above all, by the activity of its life and power for destruction. In general, cancers are divided into *encephaloid*, *scirrhus*, and *colloid*. The last has been of late discarded as a distinctive variety. It is now considered to be rather a condition, or stage of degeneration, in certain tissues, and is not absolutely confined to cancer, although it is generally associated with it. It consists of a gelatinous substance, devoid of organization, or possessing only the remains of it along with cancer cells; sometimes the latter are deficient, and the colloid substance appears to be merely the degenerated remains of fibrous tissue; hence, some suppose it to exist in cancer only, as the debris of the stroma of the tumour. These are speculations into which we need not enter here, for colloid tumours generally occur in the internal organs, intestines, &c., where they are beyond the reach of surgery. Small cysts, or granules, of it are met with frequently in external scirrhous tumours, but do not in any way influence our diagnosis or treatment. The other two forms of cancer have been sub-divided, according to the fancy of writers, into many varieties: most of them present clinical features, and may be useful for the sake of description, but are not to be considered as fundamentally different from each other. Even encephaloid and scirrhus are terms rather of clinical than scientific import. The differences which these two forms of cancer present are similar to those presented by the acute and chronic types of other diseases, and they refer entirely to the amount of activity in the development of the cancer cell. The terms are, however, so engrafted into our systems of surgery, that it would be mere pedantry to discard them, although the terms acute and chronic cancer have been adopted by some writers.

Encephaloid cancer consists of an aggregation of cancer cells, actively and rapidly developed; hence, in proportion to its rate of growth, we find the cells small, round, or oval, with comparatively few free nuclei, and an abundance of the blastemal fluid. Free organic granules, and compound granular cells, are also observed, in proportion to the activity of growth. Hence, a section of such a tumour pours out a large quantity of light yellow, or pink milky fluid, in which all these elements are readily found. The fibrous stroma, or proper tissue, of the seat of disease is pushed to one side by the rapid accumulation of masses of these cells; it, therefore, appears to have a curvilinear arrangement, and is not abundant or dense. The whole tumour is lobulated, the margins of the lobes being curved and composed of this fibrous tissue stretched and displaced; a filamentous net-work, of varying density, intersects the lobule; the cut surface is pulpy, easily scraped down, or crushed into a pinkish creamy fluid, and the entire tumour has a soft elastic feel, in the most acute cases almost amounting to fluctuation. Blood-vessels abound through the tumour, but not with regularity; for minute observations show, that large masses, composed wholly of cells, must derive their supply from vessels in contact with their outer layer, by a process of endosmosis or percolation.

The external surface of such a growth will be nodulated and uneven, but with curving outline; the integuments covering it will become tense and discoloured; their minute veins will be dilated, producing varicosities on the most prominent points, with the enlarged veins ramifying over the surface, and running in a direction from the tumour. At a later period the skin may give way; as it does, it becomes incorporated with the tumour, that is to say, cancer cells are deposited in the interstices of its fibrous tissue. From the orifice thus caused fungous granulations sprout forth, composed of cells (as all luxuriant granulations mainly are); from their surface a foul sanious or ichorous discharge is poured forth, which is composed of large quantities of broken-down cells floating in serum, or blastemal fluid, all in a state of rapid decomposition or putrefaction; pus corpuscles are also sometimes found, but not invariably, and they would appear to depend upon some accidental condition. Hæmorrhage occurs as the result of violence of even a trifling nature, when the tumour is of rapid growth and soft. Occasionally, large masses of the diseased structure die by a process resembling sphacelus: the tumour arrives at a size in which the process of endosmosis seems insufficient to carry the nutritive fluid to those parts which are not in contact with vessels, while at the same time the force of the circulation is weakened by the destructive influence of the disease, and by the waste which it occasions in the system; hence, large portions of the tumour seem suddenly to lose their vitality, and are cast off as sloughs. Unfortunately, this process does not check the disease: cancer grows most actively, not in the centre, nor towards the surface, but in the circumference where it is in contact with the sound parts; so that the part possessed of most destructive energy is left behind, and the disease spreads with increased force under the influence of the vascular excitement which the sloughing process has engendered.

Encephaloid cancer is, from its acute nature, essentially a disease of early and adult life. In the child, it most frequently attacks the contents of the orbit and the bones; in the adult, the glands, viscera, and genito-urinary organs. The female breast is, comparatively, rarely the seat of this form of cancer—at least, in England; in France and, to a certain extent, in Ireland, it appears to be less rare. When acute cancer attacks the old or the feeble, it seems to be peculiarly rapid and destructive in its character: it prostrates the strength and destroys the energies of the wretched patient; it seems as if the vital force were concentrated on the morbid action, to the interruption of all healthy nutrition, and the disease runs its course with great rapidity. Scirrhus differs from encephaloid in many particulars, such as size, form, density, &c.; all differences are, however, referrible to its chronic nature. The cancer cells are more slowly developed, and attain a larger size; nuclei, which have not yet become cells, abound; cells of every variety of shape, but more particularly fibriform and caudate, are observed, as well as fragments of cells, shrivelled or filled with oil globules. There are few organic or compound granular cells, and but little fluid; the fibrous tissue of the gland, or other seat of the disease, is hardened and condensed by the long-continued irritation, and its contractile force tends, in some measure, to check the amount of interstitial deposit; hence, a section of scirrhous tumour presents a surface intersected by straight, or radiating white lines, especially in the breast, where the fibrous remains of the milk-ducts run in all directions from the nipple; the loculi, or interspaces, are small and somewhat angular; their contents are of a firm texture, of a pale, blueish gray colour, semi-transparent, like horn, and glossy, and exude a small quantity of thin milky fluid when pressed or scraped. The entire mass is remarkably tough, hard, and heavy.

Small collections of greenish yellow colloid or jelly-like matter are sometimes interspersed through cancerous tumours. Sometimes, also, larger masses of a yellow, cheesy, or sebaceous material are to be seen; the latter is found to consist of the remains of the contents of the gland ducts, such as the salts of milk and fat, broken up epithelial cells, &c.; while the former is probably a form of degeneration of the fibrous basis of the tumour mingled with cells. Sebaceous matter and colloid are found in both acute and chronic cancer, but the sebaceous is found in larger quantities in the acute, and the colloid more frequently in the chronic type among external cancers. The external characters of scirrhus *in situ* are those of a tumour, in which condensation of structure and interstitial deposit are progressing with a certain amount of antagonism. Compared with encephaloid, it is small and less elastic, becoming finally of even stony hardness and weight. At first it may appear isolated and rolling among the neighbouring tissues, but it soon sends out processes which draw in and fix the fibrous structure of the integuments, fasciæ, or muscles near it. The skin becomes rough and seamed with lines, or indented in points; sometimes it has a hypertrophied appearance, such as it has when viewed through a pocket lens of low magnifying power. This is owing to cancerous infiltration, and is found generally in fat persons, the fibres of whose skin are not closely woven; such a cancer gets the name of lardaceous. In other instances, the skin is dotted over with small granules of cancer; or it may be only of a waxy pallid hue, and deficient in elasticity; all these alterations of the integument are elements for an unfavourable prognosis. The tumour becomes fixed to the subjacent structures, and sends processes which can often be felt towards the neighbouring lymphatic glands. These at an early period are enlarged, and become the seat of cancerous deposits. It is a curious fact, of which no adequate explanation has yet been given, that engorgement of neighbouring glands is more common in proportion to the chronic nature of the cancer. You may find large masses of encephaloid isolated in the tissues and not affecting the lymphatics, while even a small scirrhous growth rapidly poisons all the neighbouring tissues of every kind.

Œdema of the skin in the vicinity is another symptom of advanced scirrhus. We see this in scirrhus of the breast, in which we have the arm and side hard and œdematous. Ulceration commences in different ways, not often by tension of the integuments, more by a crack or fissure, or by an excoriation in a fold of skin, where secretions, perhaps somewhat acrid, lodge and excite inflammatory ulceration; this is common in the breast around the retracted nipple. Sometimes a large portion sloughs off as in encephaloid, and from a similar cause, viz., inadequate supply of nutrition. In whatever way it commences, ulceration soon destroys all the less active and central parts, and leaves a foul irregular cavity, the depressed surface and elevated edges of which are hard, undulated, and inflamed. Cancerous deposit goes on in a constantly widening circle, and with rapidity proportioned to the inflammatory or excited action of the part. Ulceration follows in a somewhat narrower circle, and destroys the older parts of the infected tissues. A foul and copious dis charge wastes day by day the strength of the patient, who, overcome by pain, at length falls into a hectic state, which puts a period to his misery. The pain of cancer is variable in degree, but always of a lancinating character. Sometimes it resembles the sudden dart of a fine needle at rare intervals; sometimes severe and constant pangs, as of the sharpest knife. There is another kind of pain complained of, when the tumour has been much disturbed by handling; this is of a deep, dull, aching character, and supervenes in an hour or two, lasting for the greater part of a day. The lancinating character of the pain is of value as a diagnostic symptom, when you are sure that your patient does not misapply the term, as is often the case. Other symptoms, which either belong or have been ascribed to cancer, will be considered, when we are treating on the differential diagnosis of cancerous and other tumours.

We shall now pass to *cancroid growths.* These are growths which possess a minute structure different from cancer, with external signs and symptoms more or less characteristic, and which resemble cancer in their clinical features, without being altogether so destructive. They hold a midway place between simple tumours and cancers. The former are mere redundancies, isolated hypertrophies; the latter are destructive interstitial deposits, destroying not merely by pressure, but by an inherent tendency to convert the neighbouring structures into their own substance.

Cancroid growths are as yet imperfectly known. *Anatomically* they appear to be more hypertrophic than interstitial; even the epitheliomata, when carefully studied, bear out this assertion. *Clinically* they resemble cancers, but are more slow of returning, or if they return rapidly are confined to the immediate neighbourhood of their original seat, and are accompanied with less waste of tissue and less constitutional disturbance than cancers. This is the general rule of such growths. Individual cases occur of great virulence and rapid destruction of life, and of general infection in distant organs, either after or without operation, and relapses after the most complete removals are frequent sometimes at very short intervals, sometimes after the lapse of years.

The commonest form of cancroid is the epithelial tumour or *epithelioma.* This growth is found in all regions where mucous membrane and skin approach each other. It may be situated on the mucous membrane, the skin, or on both; it is also found on the skin in parts where moisture abounds, as in the genital organs; occasionally on the general cutaneous surface, as in that form of ulcer called the chimney-sweeper's cancer; never, according to Velpeau, in the female breast; and certainly very rarely in any gland as a primary affection. Its anatomical element is the common epithelial cell, arranged with an amount of regularity strikingly in contrast with the irregular disorderly grouping of the cells in cancer; this regularity is only disturbed, when, by the accumulation of great numbers of cells in a tube, follicle, or other cavity, those first formed are pushed into the centre; but a little care will always unravel the primary arrangement. When the growth occurs on mucous or moist surfaces, the rows of cells generally lie in parallel bead-like lines with marked regularity, and have a great resemblance in anatomical structure to simple warty growths. The characters of the epithelial cell are—small nucleus, small size and round shape of cell when first formed, with subsequent enlargement and flattening when brought nearer to the surface, so that it comes to be the largest of all cells. Add to this, great delicacy and transparency of both cell-wall and contents, and perishable nature of the entire cell, and you have sufficient marks by which to distinguish it from any other cell, whether the result of healthy or morbid action.

Case of Lithi-uria in a Child.

BY B. WILLS RICHARDSON, F.R.C.S.I.

The following case of lithi-uria came under my observation a few months since.

The subject of the case was a boy aged three years. He was born of syphilitic parents, and was the first living child of four children, all the others having perished *in utero* some weeks before birth; and it is probable he would have shared the same fate, were it not that both parents, subsequently to the birth of the third child, had been put under a mild mercurial course by the advice of the present Master of the Lying-in Hospital, Dr. M‘Clintock. During the early part of her fourth pregnancy, the mother took a good deal of hydriodate of potass.

When brought to me, this boy was in an exceedingly debilitated state of health: he was pale, had an anæmic appearance, and his tissues were remarkably soft; he was evidently a child of very low vital power. His was a curious instance of parental oversight, for I was consulted on account of an affection of one of his knee-joints, which was not discovered by the mother until the child had arrived at the age when children should begin to walk. It was then ascertained that one knee was swollen, and that the leg was semiflexed upon the thigh, and could not be extended.

In describing the boy's symptoms, his mother told me that there was a very large deposit in his urine, and this, on examination, was proved to be altogether composed of pale yellow crystals of uric acid. Two illustrations of these crystals are given (Figs. 1 and 2), chiefly because some of them present linear markings having an appearance I have not yet seen described by any writer on urinary pathology, and forming very beautiful microscopic objects.

Fig. 1.

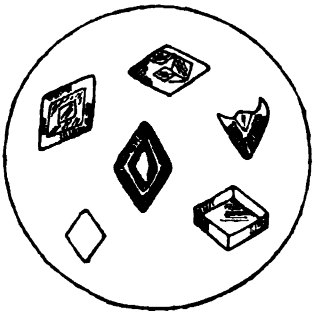
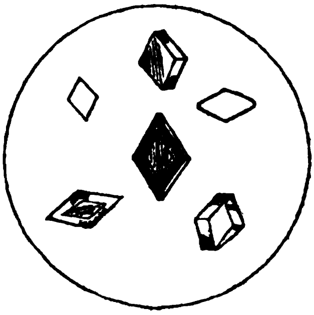


Fig. 2.



The lines converge towards what is supposed to be an inner crystal, and in some of the crystals, other lines starting from the circumference of the latter, converge also towards its centre. This appearance cannot depend upon the balsam in which they are immersed, for I have some put up dry which are marked in the same manner, but, of course, not so distinctly as the former. In Fig. 1 there is a very beautiful crystal, apparently composed of three, two inner and one outer one.

As far as I can discover, the converging lines are contained in a very thin superficial lamina, for in some of them this is partly broken off, leaving the crystals but partially marked.

Taking into consideration the bad state of the child's health, his pale, waxy appearance, the state of his knee-joint, and the history of his parents, I considered it a case of lithi-uria occurring in a person of low power, depending probably upon an unhealthy state of the blood. I determined to try the effect of iron, and I gave him a combination of the syrup of the iodide in cod-liver oil. Under the persistent use of this treatment he improved in appearance and general health, and the deposit gradually disappeared from his urine. The disease in his knee-joint is apparently arrested, and I have been enabled, by means of a light extending apparatus, to get the leg into a nearly straight position.

This case lends some support to the theory of Liebig relative to the influence of oxygen (conveyed in the red blood-discs) on the insoluble uric acid supposed to be the result of the metamorphoses of tissues. He considers that the oxygen sò conveyed acts upon the insoluble uric acid, and converts it into soluble urea. According to this theory, an excess of uric acid should be the result of imperfect oxygenation of the blood. For the arguments in favour of and against this theory I must refer to Dr. Golding Bird's work on urinary deposits.

Up to the present time the child has shown no symptom of calculus, but I am not insensible to the danger he would incur of the formation of a calculus, in case of a return of the lithic acid deposit and the neglect of its treatment.

Hospital Reports.

RICHMOND SURGICAL HOSPITAL.

Removal of a large Fatty Tumour from the Right Shoulder.

Mr. Hamilton removed a large fatty tumour from the right shoulder.

The patient was a stout drayman, in Messrs. Pim and Jameson's brewery, and had had the tumour for eleven years, but it was only very recently that it began to annoy him in carrying weights on this shoulder.

The tumour was, in circumference, about the size of the open hand, prominent, but diffused at the base. When pressed on the top, the border rose in a well-marked, uneven, lobulated margin. It had the feel, the consistency, and the elasticity of fat; not painful; the skin over the greater part of the surface was discoloured, dull red, with many small purple vessels, and coarse grained. The tumour extended from the top of the shoulder upwards to the side of the neck; its anterior boundary was the edge of the trapezius; its posterior the spine of the scapula.

Mr. Hamilton observed, that generally nothing was so easy as the removal of even large fatty tumours, the only thing necessary being, to make a free incision from one end of the tumour to the other, and down to the surface of the tumour itself, which could be easily torn out with the finger, assisted by a few touches of the knife to divide any bands of fibrous connexion stronger than usual. In the present case the skin was evidently closely adherent to the upper surface of the tumour, and the removal would not be so easy.

This opinion proved correct, as Mr. Hamilton had to dissect off the skin from the tumour, and to use the knife more freely than usual when he came to the base, where the pressure and friction by the casks and other heavy weights carried on the shoulder had caused close adhesion between the fatty base of the tumour and the surface of the trapezius muscle.

The tumour, when removed entire, was about the size of the clenched fist, and consisted of large lobules of yellow fat. No blood was lost, and the wound was brought accurately in apposition, and kept so by adhesive straps, though Mr. Hamilton observed he had no hope of union by the first intention, for, except in one case where he had removed a fatty tumour from a woman's thigh twice the size of this, and where the entire wound (except at one point where a ligature came through) united by the first intention, he had never seen adhesion take place.

Wednesday, August 29th.—Dismissed, the wound nearly all healed, fifteen days after the operation.

Removal of the Bursa over the Knee.

A servant woman, ætat. 43, admitted into No. 13 Ward, with a bursal tumour over the lower part of the patella and on the ligamentum patellæ, the usual situation. It was of nine years' standing; had lately inflamed, become painful, and burst, and now presented an angry appearance, with a deep red summit, and a ragged yellow opening, discharging thin acrid matter; it was very tender and painful, and there was some fever. The tumour was about the size of an orange, its walls very hard, of a cartilaginous feel, but it was freely moveable over the subjacent parts. On account of those two last circumstances, Mr. Hamilton thought it best to remove it entirely. By a week's rest in bed, constant bread and water poultices, and gentle medicine, the inflammation and irritation were removed from the tumour, and the patient became free from fever; on Wednesday, August 1st, the operation was performed. A long incision was made from a little above to a little below the tumour, curving a little to one side of the opening and the inflamed integuments next it; a second curved incision was made on the other side of the opening, but joining the other incision below, so that after the removal none but sound integument should be left. Mr. Hamilton then rapidly dissected out the tumour, which was readily done by keeping it pulled on the stretch, making the membranous cellular bands fly before the edge of the knife. The long wound was closed by a couple of sutures and sticking plaister; it all united immediately, except at two points.

She was dismissed on Monday, 20th, with the wound completely healed two days previously. When the bursa was examined after removal, it was quite smooth and globular, the size of an orange, with a round opening leading into its centre, which was filled by a firm, yellow, flaky substance adhering in layers to the inner membrane. The walls were a quarter of an inch thick, of a bluish grey colour, and fibro-cartilaginous consistence.

Lithotomy.

Sept. 29th.—Mr. Hutton removed a large calculus from a boy ten years of age, who was admitted into the Hospital a week previously.

The operation was performed in the manner more particularly described in a recent number of the GAZETTE. (No. XI. p. 169.) The staff, which was held by the operator, was quickly and freely cut upon, and the urethra opened from the membranous portion up to the vicinity of the bladder itself. A copious gush of urine followed; the probe-pointed knife was then carried along the staff into the bladder, the staff withdrawn, and a sufficiently free opening obtained by running the forefinger of the left hand along the back of the knife fairly into the bladder; along the finger the blunt gorget was next introduced, which last served as a conductor for the forceps. The stone was quickly seized, and extracted with ease. The operation did not occupy more than one minute. A small artery, probably the transversalis perinæi, bled rather smartly; it was, however, easily ligatured. Notwithstanding this, we have scarcely ever seen less blood lost at an operation for the stone.

Lastly, a short catheter, with a fine linen sheath (a *tampon*, in fact), was secured in the bladder, and the boy placed comfortably in bed, having been wholly unconscious of any pain, or even of his removal from the ward, thanks to the kindly influence of chloroform, which was administered to him before he was brought into the operation theatre.

Dr. Hutton thinks the danger of urinary extravasation into the cellular tissue around the bladder, is much lessened by having a short catheter in the bladder, by which the free escape of the urine is ensured. The small linen sheath, superadded to the catheter, occupies but very little more space, and admits of the immediate arrest of secondary hæmorrhage, should such supervene, without opening up the wound afresh.

Dr. Hutton remarked that he had not met with a case in which urinary infiltration had occurred, since he had adopted this practice.

The stone, as we have said, was of large size, relatively to the age of the patient; it presented a triangular outline, with rounded angles and flattened surfaces. It weighed 209 grains, and was composed of lithic acid and oxalate of lime, in distinct laminæ. One side was of a dark colour, and perfectly smooth; the other, which was light-coloured, was roughened by phosphatic depositions.

It is not unlikely that one surface of the stone—the smooth portion—had been constantly presented to a smooth portion of the mucous membrane of the bladder, or, perhaps, retained in a shallow cyst, leaving one surface free, on which alone subsequent depositions could take place. The *history* of the case renders this view yet more probable; for, on inquiry, we learned that, instead of the usual account of years of torment and suffering, this boy had suffered little or no pain until one month previously, when the usual signs of stone became, as it were, somewhat suddenly developed; yet the size of the stone indicated its existence for a period long antecedent to the time when pain was first complained of. Hence, we may, perhaps, infer that the occurrence of these symptoms only indicated the period when the stone first became loose in the bladder. Apart from some such explanation, it is not easy to understand how a calculus could have attained so large a size without the occurrence of any of the usual symptoms, until within one month of its extraction.[*]

The calculous diathesis, however, had existed for several years, as small calculi had been passed from the bladder, from time to time; and, on two occasions, Dr. Hutton had removed with the forceps small fragments which had become impacted in the urethra.

The progress of the case, since the operation, has been most satisfactory. Up to this, the ninth day, no unfavourable symptoms have appeared.

CRIMEA.

[We have received the following communication from Mr. J. C. Wright, Assistant-Surgeon in the Artillery. The case was treated by Mr. Howard, Surgeon of the 20th Regiment, and is an interesting illustration of the "Surgery of the War."]

Camp before Sebastopol.

Fracture of the Skull; Wound of the Dura Mater; Symptoms of Compression long deferred. Trephining; Autopsy.

William Holmes, ætat. 20 years, admitted into the Field Hospital of the 20th Regiment, at four, A.M. on 24th August, 1855.

Shortly before admission, while on duty in the trenches, was wounded by a fragment of shell, which struck him on the left side of the occipital bone, just above the central line. There was a wound in the scalp of about three-quarters of an inch in length, from which there had been some hæmorrhage; the dura mater was divided, and some of the substance of the brain had exuded. Several loose pieces of bone, and a fragment of iron of the size of half a horse-bean, were removed, and the wound was enlarged by a crucial incision down to the pericranium. The pulse was exceedingly feeble, surface cold, pupils neither dilated nor contracted, and quite obedient to light; patient answered questions readily and sensibly. He was placed in bed, and reaction, or the occurrence of the symptoms of compression, was looked for.

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[*] Since these observations were printed, we have learned from Dr. Hutton that he does not think that the stone in this case was encysted. "On careful examination of the calculus," he writes, "I find that the usual signs of this are wanting; the laminæ are, for the most part, uniformly deposited, and there is no sulcus or depressed line indicating the impression of the edge of a cyst. It is probable that the slightness of the symptoms depended upon the smoothness of the surface of the calculus, occasioned, perhaps, by the friction of the other calculi which were removed from the urethra. The recent symptoms, pain, &c., may have arisen from the rough deposit on the one surface—the stone resting, it may have been, by the other surface, on the smooth trigone of the bladder, the outline of which it closely represented."

9 A.M.—Warmth restored; pulse 36; pupils rather dilated, but sufficiently irritable; patient was quite sensible, and complained only of pain at the seat of the injury and in both shoulders, not extending down the arms; no other injury could be detected; patient had passed water naturally.

1 P.M.—Pulse fuller; some headache; patient asks for anything he wants; lies upon his side; respiration unimpeded; no stertor or paralysis. The scalp was shaved, and a further examination made, during which he complained of intense pain, and exclaimed violently; pulse increased in frequency and fulness. Iced water was applied to the scalp, and 20 grains of calomel administered, and two grains with a quarter of a grain of antimony continued every three hours, after the evacuation of the bowels by a colocynth enema; took blood from the arm to twenty-six or thirty ounces.

25th.—Head quite cool; patient had slept; occasionally awake and asking questions. Bowels freely purged; bladder voluntarily emptied; pulse had risen to 80. To continue the iced lotion, as also the calomel and antimony.

26th.—Progressing favourably; pulse 78; skin cool; patient is quite sensible; bowels free; respiration natural. He complains of exaggerated sensibility of the skin of the chest and upper extremities, and requests the attendant to drive the flies off him, though he is under a netting; pupils natural; bladder evacuated by his own effort.

Pergat.

27th August.—No alteration from the state of yesterday.

Continuantur remedia omnia.

28th.—Edges of wound a little swollen; some oozing of diffluent cerebral matter; headache complained of; pulse 80; pupils natural; patient lies on his side, is quite sensible, and has taken small quantities of arrow-root at intervals; bladder naturally evacuated; bowels open. Continue the pills of calomel and antimony, as the mouth is unaffected; iced lotion to be still applied.

1, 30 P.M.—Patient was suddenly seized with vomiting, succeeded, almost immediately, by profound coma and complete insensibility. The wound of the scalp was now enlarged, and a fracture was seen passing downwards; a triangular portion of bone was found to be slightly depressed. As this portion was firmly fixed, the trephine was applied immediately over the edge from which the loose particles had been removed in the first instance, and about three-quarters of a circle taken out. When this was done, the depressed tongue of bone was easily elevated. The dura mater having been wounded from the first, a little cerebral substance exuded; the stertor was for a short time slightly relieved, and the patient evinced some signs of consciousness after he was removed from the table; the edges of the scalp were laid together, and retained by a bandage, and iced water again applied. The improvement was of but short duration, for the stertor shortly returned, the respiration became laboured, and the cheeks flapped out on expiration, as in paralysis. This state continued for about four hours, when death took place.

Autopsy sixteen Hours after Decease.—The dura mater was wounded for about three-quarters of an inch. On this spot it is probable the missile directly impinged. Here two lines of fracture were found to proceed along the inferior depression (fossa?) of the occipital bone, which, joining at its lower and outer part, could be traced onwards as far as the basilar process of the bone, giving off a little branch which reached the edge of the foramen lacerum. At the upper end of the large fissure, a minute portion—a leaf, as it were—of the inner table was slightly depressed, and turned up on one side to a small extent. Some blood was extravasated under the dura mater, along the course of the fracture, over the depression (fossa) of the occipital bone, and blood was also found between that membrane and the bone, near the seat of the direct point of contact of the missile.

The striking features of this case appear to be the late appearance of the symptoms of compression. On admission, the symptoms were those of slight concussion and shock only; the patient was perfectly sensible, and the pulse exceedingly feeble. No indications of paralysis existed; on the contrary, exaggerated sensation in the arms was complained of. This was the condition of the patient up to the time of the vomiting, after which coma supervened. This was on the fifth day after the injury; and, nevertheless, it is certain that the depression of the tongue of bone, raised after trephining, must have existed from the occurrence of the injury on the 24th.

The parts have been preserved, exhibiting the whole extent and nature of the fracture.

ON THE USE OF IODIDE OF IRON.

BY JAMES TUCKER, M.D., SLIGO.

I have been in the habit of prescribing iodide of iron, rather extensively, in dispensary practice during the last two years, for scrofulous, secondary syphilitic, and other broken down constitutions—the result, in some, of the abuse or excessive use of mercurials, and in others, of those depraved states of blood and of degraded animal tissues which abnormal or deficient secretions contribute to manifest.

All anæmic states of constitution—chlorosis, amenorrhœa, chronic diseases of joints, and enlarged lymphatic glands—seem to be rapidly relieved by this medicine.

I was struck with the wonderful improvement in the health, strength, and condition of a country girl, aged 26, who suffered from phthisis for eighteen months, and was so emaciated and weakened as to be quite unable to leave home, but who now, after three weeks' trial of Blancard's pills and cod-liver oil, can walk two miles, with little or no distress, to the dispensary.

I have observed freqnently, indeed invariably, chronic and intractable sore legs and others of that class to assume a healthy healing surface under the use of iodide of iron and cod-liver oil. I did not observe the same rapid and decidedly beneficial result from the use of the oil *alone*. If I were to select from these two recuperative remedies, I should decidedly prefer the iodide of iron to the cod-liver oil, though both are best, particularly for the ill-fed portion of the lower orders of invalids.

I have prescribed iodide of iron in a few cases of tumour of the breast with marked benefit, relief of pain, reduction of tumour, and improved general health and appearance.

I was induced to make trial of the iodide of iron originally, from the following high reports of its merits by two such distinguished medical authorities as Dr. Williams and Dr. Thompson, lately professors in the London University College, whose remarks upon it I may be allowed to quote.

Dr. Williams' Principles of Medicine, page 170:—*Anæmia—Treatment.*— "Iron, in some of its forms, is unquestionably the best tonic, and in many comparative trials I have found the iodide of iron the most speedily efficacious. Besides its tonic action, it promotes the secretions more than other combinations of iron, and in some way, like other preparations of iodine, increases the freedom of the capillary circulation; by its use I have seen females restored from extreme pallidity to a rosy hue of health in less than three weeks."

Dr. Thompson—Dispensatory:—Iodide of Iron, p. 949.—"The extreme solubility of this compound, formed of two very active but little soluble bases, led me to introduce it as a powerful therapeutic agent. It is rapidly carried into the circulation, and may be detected in the secretions. It operates as a stimulant to the glandular system, whilst the iron supports and improves the tone of the habit. I have found it beneficial in scrofula in all its forms, chlorosis, atonic amenorrhœa, hysteria, secondary syphilis, and incipient cancer; in the former combined with iodide of potassium, and in the latter with iodide of arsenic. I have found it serviceable in atonic gastric dyspepsia, when combined with bi-carbonate of potassa, and taken at the moment of admixture." The dose from 3 to 8 grs. or more.

As it is of the utmost importance to have a uniform and permanent preparation of a medicine so liable to chemical change, and one with iron in excess, I consider the new and improved formula of Blancard's pills happily suited to meet the wants and wishes of the medical profession and of the public in this regard. Its extreme solubility facilitates its absorption into the capillary circulation, where, under its beneficial influence, the vital transactions are so speedily and efficaciously performed.

From my experience of this renovator of the blood, I feel assured that it will hold a high and permanent place in materia medica.

SELECTIONS FROM BRITISH AND FOREIGN JOURNALS, &c.

Syrup of Hydriodic Acid. By Mr. James Murdoch.

Hydriodic acid in a liquid form has been introduced into medicine by Dr. Andrew Buchanan, as having the therapeutical powers of iodine without its irritant action. It has also been employed by him in the treatment of choleraic disease, and, accordingly, becomes a preparation of considerable interest.

The following speedy formula he has given for preparing it:

Take of Tartaric acid, 264 grains.
Iodide of potassium, 330 ,,

Dissolve each separately in f ℥jss. of distilled water; mix the solution, agitate and strain to separate the bitartrate of potash, adding water to make up the measure to f ℥vj¼. Each fluid drachm of this solution should contain 5.072 grains of hydriodic acid, equal to about 5 grains of iodine. When the solutions are mixed, the liquid assumes a slight yellow colour, and in ten minutes after gives a slight tinge of violet with a cold solution of starch, which gradually changes to a deep blue.

This rapid decomposition appears to arise, in some measure, from the agitation necessary to effect the separation of the bitartrate, and, consequently, greater contact with the air. When hydriodic acid is prepared by the sulphuretted hydrogen process, it does not show decomposition for an hour or two after it is prepared; but if moderately agitated it shows the presence of free iodine much more speedily. It is, therefore, essential, in dispensing this acid, to prepare it extemporaneously, and supply it frequently to obtain its medicinal action. It may be very speedily prepared by the above process: and for convenience the solutions may be kept ready made and mixed when required; but as 264 grains of tartaric acid in f ℥iss. of distilled water measures f ʒxv. and 330 grains of iodide of potassium in the same quantity of water measures f ʒxiv. it will be necessary to employ them in these relative proportions. Dr. Buchanan also directs it to be taken in starch gruel, which has the chemical effect of combining with the iodine that is liberated during the time of its administration.

I find that hydriodic acid may be prevented from undergoing this decomposition when in the form of a syrup.

The antiseptic properties of sugar are well known to the pharmaceutist, in the vegetable kingdom in the case of vegetable syrups, and in the mineral kingdom in the case of certain protosalts of iron, where the presence of sugar prevents the latter from becoming peroxidized by the absorption of oxygen, as in the cases of the carbonate, iodide, and protonitrate of iron.

What method, therefore, will be best adapted for the preparation of this syrup? In the usual way of preparing hydriodic acid, by passing sulphuretted hydrogen through iodine suspended in water, the iodine is very apt to be enveloped in portions of the sulphur that is set free, and escape the action of the H S. This being guarded against, a solution of hydriodic acid could be obtained, from which a syrup might be prepared, if cautiously operated upon, that would contain no free iodine. The repugnance, however, that is usually felt by the pharmaceutist to the employment of H S, as the means of preparing pharmaceutical products, would render this process objectionable, although it should be found to be in other respects available.

With another means of preparing this acid, by decomposing a solution of iodide of barium by the equivalent of sulphuric acid, and filtering to separate the insoluble sulphate of barytes, as the iodide of barium itself is an unstable compound, it would be necessary to prepare this salt at each manipulation.

Assuming, therefore, that if a syrup can be prepared by Dr. Buchanan's solution, that shall contain no free iodine, it will furnish the most suitable manner of obtaining this acid for medicinal purposes, I have to propose the following proportions for a syrup. It is necessary, however to observe, as one of the conditions of success, that the iodide must be free from any trace of iodate of potash.

Of four different samples of iodide that came under my notice, all gave a slight iodine reaction with solution of tartaric acid and starch. These, although containing extremely little of the other impurities usually found in iodide of potassium, were contaminated with a minute portion of iodate of potash. They had been prepared by what is known as the caustic potash process, and accordingly extremely liable to contain some undecomposed iodate. But, as it is quite possible to produce a salt by this process that shall be entirely free from even a trace of iodate, I think it is only necessary to guard manufacturers against this salt occurring in their product, to make it suitable for preparing hydriodic acid. I have, accordingly, used an iodide prepared by the Pharmacopœia method of decomposing the solution of iodide of iron by carbonate of potash:—

THE SYRUP.

Take of Sugar..........℥ij. ʒss.
Water..........ʒv.

Dissolve in a flask with the aid of heat, and allow it to cool. Prepare solution of hydriodic acid as before mentioned, without adding any of the additional water. This operation should be done speedily, and it may answer for that end to strain it through calico. If paper were used, decomposition would show itself before filtration could be completed, unless the quantity was small. Of this strong solution take f ℥ss. and ℈j. and mix with the syrup. The whole should measure f ℥ijss., and each f ʒj. contain the equivalent of gr. ij. of iodine.

Or it may be prepared by dissolving the hydriodate and tartaric acid, each in syrup, instead of water, mixing them together, and letting it stand for a few hours, to allow the bitartrate to settle, and pouring off sufficient for the required quantity of syrup. With this latter mode, which appears the more feasible of the two, a slight decomposition takes place with the syrup, in the first instance, probably owing to the quantity of sugar being insufficient to preserve it; but, after being mixed with the larger portion of syrup, it remains unchanged.

Syrup of hydriodic acid, by the first method, I have had prepared since the 3rd of June, and it remains nearly colourless. I have also syrups having some colour, which have been made for several months, that have the same appearance as when first prepared. In a syrup prepared early in the winter the sugar has crystallized out of the solution, and the liquor on the surface, now weak of sugar, has a bright yellow colour, and gives a strong reaction with starch; but the crystallized portion is not affected by it unless a little nitric acid is also added, when it reacts strongly.

Hydriodic acid being gaseous it will not be possible to procure it in a solid form combined with sugar. When a strong solution is mixed with powdered sugar and moderately heated, it gives off bubbles of hydriodic acid, becoming darker in colour, reacting strongly with starch, and ultimately becoming completely black, with abundance of free iodine.

The precise action of sugar with reference to those compounds that have been named, is still obscure. Klauer considers that a regular compound is formed in the case of carbonate of iron, but the subject of this notice is an instance where the action of sugar is not confined to salts of iron.

In conclusion, it is very probable that the protective agency of sugar is exercised over many other decomposable substances that have not been examined as to this property; and if it be so, it must become of corresponding importance as a chemical agent in pharmacy.—*Pharmaceutical Journal.*

On the Primary Seat of Varicose Conditions of the Veins of the Lower Extremities.

On this subject M. Verneuil has recently read a paper to the *Academie des Sciences*, which contains some novel and interesting views. He was led, he says, to investigate the subject from the extremely opposite opinions held by authors as to the cause and seat of varices. Thus some, as Sir Everard Home, attributed them to a reflux of venous blood; others, as Boyer, to an obstacle to the returning blood. Some authors attached much importance to mechanical causes for their production; others denied any such influences. If ignorant of the seat, origin, and causes of the disease, the treatment of varices is committed to chance; hence different plans have empirically been employed, and, as might have been expected, with discrepant results. The whole history of varices is full of such contradictions. An accidental wound of the saphena has been thought to cause a varicose state of the veins of the leg, whilst the vein has been cut across with the view of curing the same condition. Pressure on the saphena has been accused of producing varices, yet Colles of Dublin, proposes to cure such by compressing the vein in the groin.

M. Verneuil states the following propositions as subjects for inquiry. They are conclusions which he has arrived at after six months of constant observation, during which time he has made twenty-one dissections, which he has placed in Dupuytren's Museum.

1. Varicose veins are not more frequent in the left lower extremity than in the right.
2. This condition never commences in the trunk of the internal saphena vein. This vessel often remains healthy even when the whole limb is covered with dilated veins.
3. The deep veins are more frequently varicose than the superficial.
4. The original seat of varices is the deep veins, and the affection thence spreads to the superficial vessels.
5. The muscular veins have much to say to the production of varices.
6. Valvular insufficiency holds a second place, but is a most important element in the disease.

The author considers the doctrine to be a bad one, that the deep veins are more frequently varicose than the subcutaneous. Boyer defined varicose to be "knotty tumours formed by unnatural and permanent dilatations of the *subcutaneous veins.*" The deep veins he considered as almost exempt from the disease.* This statement, which represented the views of surgeons before Boyer's time, was transmitted to his successors, and so fully adopted that it remains undisputed up to the present time. Some other observers admitted that the deep veins might become varicose, when the superficial veins had been for a long time, and to an excessive degree, varicose; but they always supposed that the change commenced in the latter, and ultimately extended to the sub-aponeurotic vessels. Physiology was erroneously supposed to support this opinion. The error consisted in the statement, that as the deep veins were supported by muscles, they could not become overdilated, whilst the sub-cutaneous vessels, on the contrary, being less protected, were capable of being indefinitely distended. It is true, according to M. Verneuil, that the *venæ comites* of the larger arteries are rarely or never found in a varicose condition, but the other deep veins, those which are found in the substance of the muscles, and those which communicate with the superficial veins, are constantly found to be thus affected; in these, according to M. Verneuil, varices commence, which subsequently extend to the superficial vessels. The special seat of varices is therefore in these *intra-muscular* and *inter-muscular veins.* Numerous dissections are adduced in proof of this position.

The following are the conclusions which M. Verneuil has arrived at:—

1. Whenever a varicose condition of the superficial veins exists, a similar condition of the deeper veins in the same part of the limb will be found present.
2. The reverse of this is not the case, for the deep veins may be varicose and not the superficial; sooner or later, however, the affection extends to the latter.
3. The primary seat of varix (*phlebectasis*), as it is met with in the lower extremities, is, therefore, not the superficial veins, but the deep veins, more especially the muscular veins.
4. Dissection and a correct knowledge of the arrangement of the veins justify these views.
5. These views should influence our opinion of the value of different operative proceedings.
6. The reason of relapses is thus explained. The obstinacy with which the disease returns was well known by experience, but the causes of it had not been demonstrated.—*Gazette Medicale.*

On Incontinence of Urine in Children. By D. D. SLADE, M. D., of Boston.

[We copy from *The American Journal of Medical Sciences* the following remarks]:—

Incontinence of urine in children is one of those affections with which the practitioner constantly meets; and, although in general it is one of no serious character, yet it often proves extremely rebellious to all treatment, and becomes exceedingly annoying to the medical man, not only from its obstinate persistence, but from the very fact of its apparent insignificance.

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* Traitè des Maladies Chirurgicales, tome ii. p. 451.

The discharge of the contents of the bladder and rectum takes place involuntarily in early infancy; but as the child advances in age it acquires a control over the sphincters, being prompted to this by a sense of decency, as well as by other influences. The involuntary discharge of the contents of the bladder may, however, from a variety of causes, be kept up to the age of puberty, and even later, proving a source of inconvenience and extreme mortification to the unhappy subject of it.

We shall arrange these children who suffer from incontinence of urine into three classes. In the first class, the affection is constant, and due to special causes which need not occupy our attention here. In the second, it is intermittent in its character, occurring in the day as well as in the night; while in the third class it is nocturnal only.

In the second of these classes, which constitute cases by no means rare, and much less amenable to treatment than those where the affection is only nocturnal, the urine passes off involuntarily, not only during sleep, but also during the day; the patient not unfrequently finding his clothes wet without having been conscious of having emptied the bladder. Moreover, he is at all times obliged to urinate more often than natural, and can scarcely ever resist the desire the moment it is felt. This form of incontinence is intermittent, the patient at certain periods being almost entirely rid of his complaint.

It is also, we think, more often found among children of a lymphatic temperament, and who require a tonic treatment; and it even appears to be hereditary, as we have seen several members of a family afflicted as were their parents before them. This hereditary tendency is also seen in the nocturnal form.

In some of the cases of the above class, the urine is copious, pale-coloured, and of low specific gravity, but very frequently neither the quality nor the quantity of urine seems to be at fault, but there is a peculiar morbid condition of the urinary organs. This condition, as Gross remarks, is undoubtedly due to a morbid irritability of the neck of the bladder, to an exaltation of the natural sensibility of that part, often unaccompanied by any appreciable change of structure.

It may also depend wholly, or in part, upon sympathy with a diseased condition of the rectum, vagina, uterus, or kidney.

The cases coming under the third class do not always constitute a malady, properly speaking, but often merely a habit. M. Petit separates children suffering from the nocturnal form of incontinence only into three categories. The first is made up of those who are too lazy to rise from bed in order to satisfy Nature at her first bidding. The second, of those who sleep so soundly that the sensation which precedes the desire to urinate is not sufficient to awake them; the neck of the bladder is the only portion which feels, so to speak, and which, accustomed to obey this sensation, opens mechanically and suffers the urine to pass without the brain being warned. The third, of those who dream that they are urinating against a wall, or into a vessel, &c.

The incontinence of the first and last categories does not depend upon any pathological condition of the urinary apparatus, and its treatment consists entirely in the adoption of moral means. That which comes under the second category is alone to be referred to a morbid condition, and is thus explained by M. Barrier, in his *Traité Pratique des Maladies de l'Enfance*:—

"It is easy to conceive how infancy predisposes so powerfully to nocturnal enuresis. At this age the muscular system of organic life enjoys a contractility much more pronounced; all the reservoirs which are provided with this are more frequently emptied. Now, the bladder has a muscular coat, the contractions of which, at least in part, are under the influence of the ganglionic system of nerves, and, therefore, removed from the influence of the will. During the day, the effects of these contractions are prevented, either by the simple tonic force of the constrictor muscles of the neck of the bladder, or by their voluntary contraction; but sleep, which abolishes all voluntary contractility, has no such effect upon the sensible organic contractility.

"It would, perhaps, be even easy to show that this latter is augmented during sleep. However it may be, the suppression of the will during sleep destroys the equilibrium existing between two powerful antagonists in favour of that which naturally predominates in infancy.

"Sleep also abolishes the functions of sense and of intellect more completely than those of instinct, consequently many of these last are performed during that state.

"Other influences also act in a similar manner, such as those dependent upon a feeble constitution, upon a lymphatic temperament, and upon inheritance. As to the occasional causes, it is easy to understand that drinking in large quantities, or forgetting to make the child empty the bladder before retiring, the warmth of the bed, &c., ought to favour the involuntary emission of the urine.

"A circumstance which tends to keep up this affection, is the habit which the bladder soon acquires of emptying itself at certain hours, under the influence of the causes of which we have spoken. We know that the frequent repetition of the same act contributes to its maintenance by the most trivial causes; all our organic functions, as digestion, the excretions, &c., are subject to the laws of habit. The influence of habit, then, partially explains the obstinate persistence of nocturnal enuresis, which is often prolonged to adolescence in spite of all remedies."

M. Civiale differs from most authors as to the cause of nocturnal enuresis in children. He remarks that he has observed this condition in subjects whose bladders, being in a sluggish state, were continually distended by a certain quantity of urine, and that the incontinence here observed is due to a veritable overflowing, analogous to that which happens in every form of retention.

If such is the cause of this affection, and as frequent a one as M. Civiale would lead us to suppose, how does it happen that this overflowing takes place only during sleep? We cannot deny that such a cause may operate in rare cases, and the very existence of it should lead us to be very guarded in our diagnosis and treatment.

M. Caudmont, of Paris, has advanced the opinion that incontinence of urine in children is often dependent upon what he terms "a contraction of the neck of the bladder," comprehending under the term "neck of the bladder," not only the urethro-vesical orifice, but the prostatic and membranous portions of the urethra, extending from the above orifice to the triangular ligament. The involuntary and permanent contraction of the muscular fibres of this part of Guthrie's and Wilson's muscles gives rise to a variety of symptoms, which are generally described by authors as dependent upon a neuralgia or *névrose* of this region. To this permanent contraction, or rather to its consequences, M. Caudmont attributes incontinence of urine, and accounts for the beneficial action of belladonna, of which we shall soon speak, by its power of overcoming this condition.

M. Civiale describes this very contraction in speaking of vesical neuralgia:—

"The sensibility and contractility of the neck of the bladder being intimately connected, the augmentation of the one ought necessarily to modify the other, and thus create trouble in the functions of the bladder. We shall see, in fact, when we come to examine the diseases of this organ, that this contraction of its neck plays a great part in most of the affections by which it is attached."

We saw, while under M. Caudmont's instruction, sufficient to convince us that his views upon this point were very just and well-founded; and, moreover, that they were confirmed by his successful mode of treatment. We shall, at some future time, explain more fully this "contraction of the neck of the bladder," and describe its intimate connexion with several other common and obstinate affections daily presented to the notice of the practitioner, the causes of which have been heretofore very obscure.

We shall not speak here of those specific causes of incontinence of urine, such as stone, paralysis, &c., but shall pass on to the treatment of this complaint.

If our knowledge respecting the causes of the common forms of enuresis in children is thus vague and hypothetical, can we offer anything more satisfactory respecting its treatment? This may be quickly decided.

First.—Of the treatment of those cases where the incontinence is by day as well as by night. The treatment of this form should be general and local.

The first has for its object to overcome the influence of hereditary disease, which has a tendency to debilitate the constitution. This end may be best brought about by proper attention to diet, which should be plain, and, at the same time, generous and nutritious; exercise in the open air, regulation of the bowels, cold bathing, if it can be supported, and the use of a proper course of tonics. As in this form of incontinence particularly, there is more or less morbid irritability of the neck of the bladder, we advise the use of sedatives. Any unnatural condition of the urine must, of course, be corrected.

By the local treatment we propose to modify any undue sensibility or irritability of the bladder. This comprehends douches of cold water to the sacro-lumbar region, the application of blisters to the sacrum and perineum, the occasional passage of the bougie, and, in extremely obstinate cases, even a slight cauterization of the neck of the bladder.

Second.—Of the treatment of those cases where the incontinence is entirely nocturnal. As with many children this form of enuresis is cured spontaneously, towards the age of four or five years, we should be careful not to pursue a too active treatment before this age, in endeavouring to overcome what, after all, with them is an affection of small importance; but, when it is proper to interfere, we must first advise the influence of moral means, which should never be harsh or cruel, but just sufficient to awaken the child to a sense of shame.

This has especial reference to those cases where we suppose the trouble to be the result of laziness; if this be the case, we cannot make the habit too disagreeable to the individual. What we have already said as regards the general treatment in the other form, is also applicable here. The diet should be mild and unirritant. The supper should be taken at an early hour, and nothing should be given after this. The child should sleep on a mattress, with just sufficient clothing to be perfectly comfortable, and should be aroused two or three times, if necessary, in order to empty the bladder. Most writers speak of the importance of the position to be kept during sleep, viz., upon the side, and not upon the back. We agree with Dr. Condie, who remarks that the position of the child during sleep is of little or no consequence, the discharge from the bladder taking place, no matter what may be the position. The trouble is, doubtless, often kept up by mere force of habit; and if the particular hour can be ascertained when the involuntary discharge takes place, and the patient awakened just before the occurrence, and made to empty the bladder, he soon acquires the power of retaining his urine during the entire night.

Sometimes also the affection is due to an irritation produced in the neighbouring parts by the presence of ascarides. We should always bear this in mind in making up our treatment, and direct it accordingly.

We come now to speak of internal remedies, some of which have received high encomiums, without, we think, sufficient grounds. Strychnine and cantharides are highly recommended by almost all writers, the latter carried to the extent of producing slight strangury. Gross speaks favourably of this remedy, which he states has succeeded where everything else has failed.

When any irritability exists about the bladder, copaiba in small doses, and cubebs in powder, have lately been highly extolled. Dr. Deiters recommends, from his own experience, the effects of the latter medicament in tolerably large doses, given twice a day during a period of from three to eight weeks. A small anodyne at night, in the form of a Dover's powder, often exerts a beneficial effect. But it is to belladonna that we wish particularly to call the attention of the profession. M. Trousseau has been most instrumental in bringing this substance into notice, as being applicable to these particular cases of incontinence in children, and we can testify to its highly beneficial effects in several cases in our own practice, besides those which we observed in the *Hôpital des Enfans Malades*.

The following is from the clinical lectures of M. Trousseau:—

"This infirmity I consider a neuralgia, or *névrose*, and it is much more common than is generally believed. It has been thought nearly incurable; but, with belladonna, is one of the most easily cured of all diseases.

"*Those children who are troubled in the day-time are not cured by belladonna.*

"A child going to bed with an empty bladder will pass his water during the first two hours, sometimes during the first hour; placed in bed at nine o'clock, the bladder will throw off its contents at ten o'clock, and then retain them until eight o'clock the following morning, being full at that time. The accident generally happens once only during the night, but sometimes twice. During the first hours of sleep, you generally find in young men and children an erection. The question may be asked, whether something of the same kind may not take place in the bladder. This complaint is most common among young girls, and is generally cured spontaneously at the age of puberty; but when this is not the case, do what chance has shown to be efficacious.

"Two young girls afflicted with hooping-cough were treated with belladonna, and were cured both of the cough and the affection now under consideration.

"*Treatment.*—The first precaution is to break up the bad habit of the organs. Wake the child at the end of an hour, and make him pass his water; after several days, wake him at the end of an hour and a half. This is only accessory.

"Give, at the moment of going to bed, ext. belladonnæ in pill, commencing with gr. $\frac{1}{5}$, waking the child as has been described. After eight days, increase the dose to double; at the end of eight days more, treble it, waking him later and later, and finally not at all. When during fifteen days he has been free from the difficulty, diminish the dose, or give it only every second day, then every third day, &c. Even if the child does not regain its bad habits, renew the medicine after two, three, and sometimes five months' cure, for he may then again begin to wet the bed. Resume the medicine as first given, several times, making the intervals longer and longer.

"The incontinence may be aggravated by eczema, caused by the constant irritation of the urine; and the urethra becoming inflamed, the desire to pass water is increased. For this state of things a sol. sulph. zinci is the best application.

"If belladonna fails, try strychnine, flagellation, and stinging with nettles. The two latter may be useful as means of intimidation, or perhaps they may have some reflex power."

So far as our experience goes, we have derived very satisfactory results from the use of belladonna in several cases of nocturnal incontinence. But, as Trousseau explicitly says, it did not have the same good effects in those cases where the enuresis occurred during the day, although it greatly relieved the trouble. We have, however, found that a larger dose was required than is recommended by that physician, in order to have the desired effect.

Reasoning from what we have stated as to the probable causes of this affection, when it occurs during the day as well as night, we should be led to suppose that belladonna was even more applicable in this than in the nocturnal form only. Practical experience, however, shows that such is not the fact.

It remains for us to speak of mechanical contrivances for the removal of this complaint. The old method of tying the penis is absurd; but certain compressor bandages, such, for instance, as the one which Trousseau recommends, may be of service when other means have failed. This is composed of an elastic band placed about the body, supporting at the back a steel spring which reaches to the anus. To this is fitted a metallic plate, on which is fixed a truncated cone of india-rubber, about two-thirds of an inch in diameter at the base. The pressure should be made directly upon the middle line of the perineum, and may be regulated by introducing the cone more or less deeply. The compression thus acts as a sphincter upon the prostatic portion of the urethra. The same beneficial effects may, as Gross remarks, be derived from the use of a bit of bougie placed along on the under surface of the penis, the point projecting a short distance beyond the gland, and retained in its place by strips of adhesive plaster. In this way, the walls of the urethra are so approximated that no urine can pass. Of course, it must be removed when necessary to empty the bladder.

For girls, M. Trousseau makes use of an india-rubber bag, which is introduced beyond the hymen, and by means of a tube inflated with air, which is retained by a stop-cock. This contrivance presses upon the lower part and neck of the bladder, preventing the escape of urine. In the morning, the instrument being emptied of air, it is removed or reapplied according to circumstances.

Such are the principal considerations which we have to offer upon this *bizarre* affection. Much is yet left to be discovered as to its causes and proper treatment, and this knowledge is only to be gained by long-continued and persevering observation. We may hope, at some future day, to contribute the results of our experience towards such a desirable end.

On the Use of Oil of Valerian in the Typhoid Disease. By J. Leasure, M.D., of New Castle, Laurence County, Pa.

About the middle of September last, we were visited by a rather mild epidemic dysentery, which did not spread with any alarming rapidity, nor was it attended by any unusual symptoms, except that there was a much greater discharge of pure blood than we had been accustomed to meet for some years in our epidemic dysenteries.

About the same time we had a few cases of our usual autumnal remittent fever, and also a number of cases of masked intermittent fever, or "dumb ague," as it is familiarly called in many portions of the Western States.

Towards the latter end of the month, all these forms of disease seemed almost insensibly to pass into the abdominal typhoid disease, familiarly known in some localities as typhoid fever, and which is frequently confounded with a low form of the regular remittent fever of this and some of the adjoining malarious districts, and which is also called typhoid fever.

Though called by the same name popularly, and sometimes professionally, it is hardly necessary to specify the distinctive differences between the two diseases; suffice it to premise, that the disease which we propose to treat of in the following remarks, is that form of fever in which the principal lesion is in the mucous follicles of the alimentary canal, and generally accompanied by a diarrhœa, always recognizable after having been once seen, and unfortunately only too familiar to many of our professional brethren, in districts where it is an annual but unwelcome visitor.

Case.—On the night of the 6th of October last, I attended Mrs. W., aged 26, in labour with her third child. Presentation natural, of the vertex, and labour over in an hour and a half. Had not felt quite well for a week previous, having had some dull pain in the forehead and lumbar region, but bid not go to bed or take medicine. On visiting her the second morning after her confinement, on looking at her tongue, I found it presenting the same appearance as the tongues of some of my patients labouring under the typhoid disease. Still, she had no fever, nor any unusual tenderness over the abdomen, and I concluded to wait for further signs of mischief before commencing active medication, for what might only be a coincidence in appearance between the tongues of Mrs. W. and my typhoid patients. There were four or five cases of the fever next door, and I left orders that if there should be any diarrhœa, or other untoward system, before my return, I should be immediately sent for.

I was not sent for, but, on my visit next morning, I found her labouring under an attack, having all the characteristics of a very violent bloody dysentery, and which had commenced some hours previously. The pulse was 120; skin rather cool and moist, with an anxious, haggard expression of countenance, indicative of deep abdominal distress. There was no unusual tenderness on pressure over the abdomen, except a little soreness in the right iliac fossa; lochia continued natural. This state of affairs gradually changed until the case presented all the characteristics of typhoid fever, as manifested in my other patients labouring under the legitimate disease. Still, the lochia continued normal in *quantity*, but very dark and fluid, like dirty water containing the washings of bloody meat. The discharges from the bowels were the dirty-brown dejections nearly resembling old beef-pickle, so common in my other cases, and the mental and physical signs altogether were of the most discouraging character. I supposed, of course, that the case was hopeless, as neither I, nor any of my professional friends whom I consulted, had ever known a recovery from an attack of the real abdominal typhoid disease in a lying-in woman. I attempted to moderate or control the excessive diarrhœa by a free use of opiates and such astringents as answered the purpose in the other cases. I gave oil of turpentine, till satisfied that it was of no avail. I gave nitrate of silver, in the vain hope that it would accomplish something, but it seemed to have no observable effect even when given in doses of a grain and a half every hour for many consecutive hours. During all this time, up to the ninth day after confinement, there was milk in her breasts sufficient for her child, which I permitted to nurse from the opinion that it *might* have a salutary effect on the mother, and because I entertained no fear for the child, as no cases of the disease had as yet attacked young children. (The child was not injured, and lives yet.)

At this period (the ninth day after confinement), milk ceased to form in the breasts, and the patient gradually grew weaker until the 25th, the nineteenth day after labour, when I found her to all appearance moribund.

The diarrhœa had continued at the rate of from five to eight discharges in twenty-hours, sometimes involuntary; and, about two o'clock on the morning of the 25th, she began to vomit. When I visited her at eight o'clock in the morning, I found her vomiting a dark-brown substance resembling muddy coffee, which was ejected out of the mouth as out of a spout, and where it ran over her linen and that of the bed, it stained them a dirty-greenish colour mixed with brown.

Her extremities were entirely cold, pulseless, and bedewed with a clammy sweat; her eyes were sunken into the bottom of their sockets, and her lips and nails blue, as I have witnessed in the collapsed stage of Asiatic cholera. Indeed, the whole appearance of the patient resembled a case of malignant cholera in the last stage. Believing the case hopeless I did nothing until two o'clock, P.M., when I visited her again, accompanied by my friend, Dr. J. H. M. Peebles, who coincided with me in a most unfavourable prognosis, but suggested the use of small potions of hot brandy and artificial warmth to the extremities (mustard had been freely applied without any effect). At nine o'clock at night I visited her again, and found her in *statu quo*.

The hot brandy was thrown up as fast as swallowed, and the extremities were as cold as before, notwithstanding the artificial heat which had been constantly applied by hot bricks and bottles of hot water. I felt loth to go away without at least seeming to *want* to do something, and some passing thought, I scarcely know what, suggested the use of small doses of the oil of valerian frequently repeated. Possibly, I thought it might stop the vomiting; or, peradventure, if retained in the stomach, it might stimulate the nervous power which seemed so greatly deficient in this as well as my other typhoid patients. I ordered one drop of the oil of valerian every hour, and that the artificial heat be continued to the extremities.

26th. *Morning.*—Patient still living; has not vomited since two o'clock this morning, and but twice since she took the oil of valerian. Some warmth has returned to the extremities, and there is pulse at the wrist, small, quick, and one hundred and thirty-two strokes to the minute; no diarrhœa; medicine to be continued as before. *Evening.*—Extremities quite warm; pulse 120; profuse warm perspiration with a most disagreeable odour; no vomiting since last visit; one voluntary discharge from the bowels, of same appearance as before; nails and lips becoming more natural in colour, and patient says she feels a little better; medicine as before.

27th. *Morning.*—Patient rested quietly; took her drop of oil every hour; vomited none; mind seems clear; had two dejections, the last a little more consistent; still sweats profusely, and same disagreeable odour from it, and the sweat stains the linen of a dingy yellow colour; says she feels better, and *is hungry*. To have a little beef-tea; medicine as before. *Evening.*—Has not vomited; has had one discharge from the bowels, more consistent than any former one; has taken half a pint of beef-tea; asks for wine; pulse 100. To take beef-tea and oil as before, and half a tablespoonful of port wine whenever she asks for it.

28th. *Morning.*—Rested quietly; slept some between doses; no vomiting; one operation on the bowels almost natural in colour, and no longer watery; pulse 100; still sweats, and same disagreeable odour; warmth natural; feels stronger. To take one drop of oil of valerian every two hours; beef-tea and wine as before. *Evening.*—Says she has had a "good day;" no vomiting or nausea; no operation on the bowels; does not sweat so much; pulse 98, soft, and tolerably full. To take the oil every three hours during the night; beef-tea and wine *ad libitum*.

From this time she gradually recovered. The oil was continued at longer intervals for a few days longer; the diet was cautiously made more solid and stimulating, and, on the 2nd of November, the milk began to return in her breasts, and in a week from that time she dismissed her nurse and took charge of her child, and may now be said to have perfectly recovered.

During the progress of this case, and before I had used the oil of valerian, I had a patient, a fine young man, who died from the typhoid disease under symptoms of pure prostration, or perhaps more properly from a want of recuperative vigour of the nervous system, which refused to respond to all the stimulants I addressed to it. This, indeed, seemed to be the principal difficulty to contend with in every instance, and that, too, from a very early period in the sickness.

The marked change which followed the use of the valerian of oil in the case of Mrs. W. led me to try it in other low cases of the same disease, though without being very sanguine of the same success; for, after all, nature, and not the remedy, might have deserved all the credit of her recovery. The other cases were not accompanied by the same extreme state of affairs as to vomiting, prostration, collapse, &c., but the same result followed, viz.: the most profuse sweating, with the same odour, and lasting from one to four days, and in every instance followed by a rapid amelioration of all the disagreeable and dangerous symptoms.

I now felt encouraged to give the oil a trial in the early stage of the disease, and in doses of one or two drops, varying in time from two to four hours; it early induced a copious diaphoresis, speedily followed by a mitigation of the disease. After I commenced a general use of the oil, I rarely gave any medicine for the diarrhœa, which mostly subsided as soon as the sweating began, and if the bowels were entirely closed for a week or ten days, I rarely interfered, for I found the patients steadily improve with a constipated state of the bowels, and I was only too well satisfied to "let well enough alone." In two or three instances I gave a teaspoonful of castor-oil, with eight or ten drops of oil of turpentine, where I thought an aperient indicated. I have, in all, treated twenty-two cases as above, some of them complicated by pneumonia with profuse bloody expectoration, and in which I did not find it necessary to make any addition to the treatment with the oil of valerian.

Other cases I have treated without the oil, but they were my mildest cases, and did not progress so satisfactorily as the more grave cases treated by the oil alone.

One patient treated with the oil, after seeming to be convalescent for a week, suddenly died, with all the symptoms of perforation of the intestine.

Pari passu with the progress of these cases, I had a couple of cases of very violent delirium tremens, in which I wished to avoid the use of opiates and alcoholic stimulants, and used the oil of valerian in the same small doses frequently repeated, as in the typhoid disease, and, unquestionably, the delirium subsided while the patients took the remedy, and returned with violence as soon as it was suspended a few hours, to subside again as promptly under its resumption.

In my typhoid cases there was little or no delirium where I gave the oil, while it was a very troublesome symptom in *all* the cases in which I did *not* use it, and one which I have always found very annoying in my former experience with the disease in question.—*American Journal of Medical Sciences.*

Malignant Tumour of the Axilla: Removal. By Mr. Erichsen.

The patient, an elderly man, was at one time in Canada, and had frostbite of his left forefinger, for which it was amputated. In July, 1854, he perceived a tumour in the left axilla; it increased, and now is the size of two fists. The favourable circumstances of the case are, the tumour being moveable, the general health good, no constitutional or malignant symptoms being present, which, together with the man's anxiety to get rid of the tumour, decided Mr. Erichsen to remove it.

The man being completely under the influence of chloroform, on the 27th June Mr. Erichsen made an elliptical incision over the tumour, from below upwards, and dissected the posterior part out first of all; he subsequently detached the tumour from the scapula and side of the chest; he then divided the attachment anteriorly; a good deal of the tumour was under the great pectoral muscle, beneath the dense fascia; and in the course of the operation he used his fingers very much in assisting to detach the tumour in its deep insertions. As it was, the axillary artery was exposed an inch or more; the whole of the tumour was, however, removed, except a small piece behind the axillary vessels, which could not be interfered with, and which would have been imprudent to remove without considerable risk. This part not being removed was tied strongly with whipcord, as also was the base of the tumour, which formed a sort of a pedicle before complete separation. In this way Mr. Erichsen hoped all the tumour would be pretty well enucleated. Many small vessels required tying. The wound was filled with wet lint, and the patient was removed.

On examining the tumour it was found to be capsulated, and on making a section it appeared what Mr. Liston used to call a "strange distempered mass," but was evidently malignant—either cancer or some other form of disease.

This man succumbed a few days after from an attack of pleuritis, with purulent effusion into the chest.—*Medical Circular.*

DUBLIN: PUBLISHED BY W. B. KELLY,
8, Grafton-street.
LONDON: S. HIGHLEY, 32, Fleet-street.
EDINBURGH: MACLACHLAN & STEWART.
October 1, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.
SENT FREE BY POST.
Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 18.—Vol. II. OCTOBER 15, 1855. Price 5d.

Lectures on Diseases of the Stomach.

BY DR. LEES,

PHYSICIAN TO THE MEATH HOSPITAL, LECTURER ON PRACTICE OF MEDICINE.

No. I.—*Acute Gastritis.*

In some introductory observations on the "Pathology of the Stomach," Dr. Abercrombie remarks, that "from various causes, diseases of the stomach have presented a wide field for speculation, conjecture, and empiricism; a vague and indefinite phraseology has often been allowed to take the place of principles; and the whole subject is removed, in some measure, out of the usual limits of pathological inquiry. Amid this uncertainty, we must endeavour to discern what is truth; and should this prove to be more limited than a slight view of the subject might lead us to expect, something will at least be done by ascertaining its extent, and tracing the course by which it may be enlarged." The importance of the subject, the great advance which has been made within the last few years in our knowledge of these diseases, by the aid of animal chemistry, as well as by the use of the microscope, the numerous valuable specimens of disease of the stomach and other viscera of the abdomen, which have been exhibited at the meetings of the Pathological Society of Dublin, by the various medical officers attached to the several hospitals in this city, and the advantages I have myself possessed, as Physician to the Meath Hospital for a number of years, will, I trust, be considered a sufficient reason for submitting to the profession some observations on the diagnosis and treatment of diseases of the stomach and abdominal viscera.

I shall not occupy time or space by entering into the subjects of anatomy or physiology, as they are fully treated of in works specially devoted to their consideration, but will commence at once with the diseases of the stomach, as I conceive they are among the most important which demand the attention of the student, and the most frequent, as well as the most difficult, that the practitioner is called upon to treat. Many are of that form termed *functional*, leaving no morbid appearance discernible after death; many are what we term *organic*, in which there is decided and evident change of structure, in some cases amounting to great disorganization, and interfering not merely with the vital, but also with the mechanical action of the part; while in others, the appearances are of so doubtful a nature, that they do not afford sufficient ground for the application of any precise principle in pathology; but they all resemble each other in many of their symptoms, causing much distress, both mental and bodily, to the patient, and much anxiety to the physician. We are often able, however, to render essential service to the sufferers, either by curing the disease, if it be of an inflammatory or merely functional nature, or by relieving the more distressing and dangerous symptoms, even though there exist incurable organic disease. And if we did nothing more than prevent the often injurious though well-meant efforts at cure, to which the sufferers from organic diseases, particularly cancer, are too often subjected, it should entitle us to the gratitude of the afflicted, and form a consolatory reflection to the well educated physician.

The most simple and pathologically accurate classification of diseases of the stomach is into—first, *inflammatory* affections, expressed by the terms acute, sub-acute, and chronic gastritis; second, *specific* diseases, which properly come under the class of organic, and include the various forms of cancer, the simple or chronic ulcer; third, *functional* disorders, which are independent of any appreciable change of structure, although attended with severe symptoms, as pain, vomiting, pyrosis; fourth, *sympathetic* affections, depending on disorder in some other part of the system.

Acute gastritis, by which term I mean to imply acute inflammation of the mucous membrane of the stomach, is a disease so seldom met with as an idiopathic affection in this country, that our knowledge of its anatomical characters and symptoms is chiefly derived from the result of irritant substances directly applied to it, especially the mineral acids and arsenic. Andral has recorded some cases where it occurred as an idiopathic affection, or as the sequel of rheumatism, or of epidemic cholera. In these cases the stomach was generally contracted, so as to resemble the transverse colon, the mucous membrane, over nearly its entire extent, was coated with a viscid thready mucus, and of a bright red or brown colour, at the same time thick, soft, and very friable, so that in no part could it be detached in strips; but it gave way under the forceps, resembling a pulp without any consistence. On its free surface there were many small red or blackish points, which seemed to have their seat in the villi, but the body of the mucous membrane itself was red, as if penetrated with blood, and spots of ecchymosis were also present. Mere redness, however, is not a certain sign of inflammation, as was long since established by Yelloly, Billard, and others; besides, we have constant proof that any mechanical obstacle to the circulation, as in cases of disease of the heart and liver, will cause deep redness of the gastric mucous membrane, depending on venous congestion, quite independent of inflammation, but owing to that vital contraction of the arteries which takes place at the close of life, and carries on the blood to the veins, after the further supply of fresh blood from the heart is stopped. This form of redness is generally diffused, and occupies the most depending position of the part, being influenced by the force of gravity, is attended with an empty state of the arteries, and with a full state of the larger veins; but the redness that belongs to inflammation is generally circumscribed, and not very extensive; it occupies the upper or lower side of the part indiscriminately, is attended with fulness of the corresponding arterial trunks, and frequently an empty state of the veins. As a general rule, therefore, do not let the mere circumstance of there being redness in a part decide your opinion as to inflammation having been there, unless you can find other proofs of its presence; and of these (in mucous membranes) softening is one of the most important, the membrane not peeling off in shreds, as is the case when in a normal state.

Suppuration rarely takes place in the parietes of the stomach, but there is a case of it in the museum of Guy's Hospital. It was taken from a married woman, æt. 40, a nurse in the hospital, who was admitted in May, 1847, under Dr. Babington, complaining of pain in her stomach, with vomiting of a dark-coloured fluid, intense thirst, then restlessness and stupor, followed by death. The stomach presented a firm mass of recent pus and lymph, about 4½ inches in length, effused between the muscular and peritoneal coats. The mucous membrane corresponding to the centre of the thick red portion presented a dark brown patch, about the size of a shilling, and also a few points of ecchymosis here and there. The posterior part of the right lobe of the liver was dark, congested, ecchymosed, and lacerable; there was also peritonitis. The thoracic viscera were healthy, it was probably caused by violence, though no certain history could be obtained. Rokitansky states that, in some rare cases, the stratum of submucous tissue is distended with pus, which exudes into the cavity of the stomach by numerous irregular cribriform openings, but this is generally the result of a low form of erysipelas, or may occur as a secondary process, analogous to the metastases of specific acute dyscrasiæ. According to the same authority, false membrane, or as he terms it, croupy inflammation, is met with in the stomach as a sequela on degeneration of exanthematic processes, in variola, in typhus, in pyæmia, and particularly in puerperal phlebitis; in these cases it sometimes invests the entire stomach, and presents a regular areolar surface; he also states that tartrate of antimony may produce a similar effect, but that it is commonly limited to a few streaks. In a specimen exhibited at a meeting of the Pathological Society by Professor Smith, the mucous membrane in some places was black, as if sulphuric acid had been taken, but there was no abrasion of the œsophagus or stomach, and a careful analysis, conducted by Dr. Apjohn, failed to detect any poison. Ulceration, sloughing, and even perforation have occurred in some cases of acute idiopathic gastritis; these sequelæ, however, are seldom met with except from the action of corrosive poisons, but you should be aware that arsenic frequently produces no local effect, particularly in cases where the symptoms of poisoning and death follow rapidly after the introduction of small quantities.

Symptoms.—The attack may commence suddenly, or may be preceded by the ordinary general symptoms of acute inflammatory disease, such as high fever, burning dry skin, quick pulse, hurried respiration; there is great anxiety and restlessness, throwing off the bedclothes; the tongue is generally of a bright red at the point and edges, but its surface is covered with a thick yellowish-white fur, and the patient complains that it feels thick and sticky; there is headach and total absence of sleep; the urine is very high-coloured, acid, and scanty; and the bowels are constipated; there is often a sharp hard cough, with a peculiar jerking respiration, owing probably to the instinctive rapid contraction of the diaphragm; the countenance is often sunken, and the prostration is very great.

Of the local symptoms of gastritis, *pain*, referred to the epigastrium, and increased on pressure, is one of the most constant and remarkable, though it varies in different individuals, in some being a severe burning pain, in others rather a painful sense of constriction; thirst for cold drinks; *nausea*, recurring frequently; *vomiting* of intensely bitter fluid, often of a bright green colour; *dysphagia*, probably caused by spasm at the cardiac orifice of the stomach; *hiccup*, one of the most distressing accompaniments of this disease, and though generally a late symptom, yet it may occur at the very commencement, and has been then considered by Dr. Stokes and others as indicative of inflammation round the cardiac orifice of the stomach. A case of this kind occurred in the Meath Hospital under the care of Dr. Stokes, in which, after the sudden disappearance of pneumonia of the lower lobe of the left lung, the patient was attacked with vomiting, followed by severe hiccup. There were extraordinary prostration of strength, thirst, and a craving for cold and acidulated drinks; the epigastrium was tender, and the bowels were confined; the tongue was clean and moist: the hiccup continued incessant even during sleep, though then somewhat modified. Notwithstanding active treatment for the gastritis, death took place on the fourth day of the abdominal disease. On dissection, we found that the inflammatory action was circumscribed in a most remarkable manner for about three inches round the cardia. Here the mucous membrane was of blood-red colour, thickened and softened, while that of the rest of the stomach was perfectly healthy. The lower portion of the œsophagus was vascular, and the cuticle separated so as to form shreds on the surface of the tube. A similar state of parts was recently observed in another case in Dublin, in which incessant and intractable hiccup was the prominent symptom.

In persons who have died suffering from incessant hiccup after severe sea-sickness, the cardiac orifice of the stomach has been also found inflamed.

Hiccup may, however, be met with as a prominent symptom in diseases of other parts, and is then a result of sympathetic irritation, as occurred in a case lately under my care in the Meath Hospital. A man, ætat. 35, was admitted, suffering from severe hiccup; his face was deadly pale and collapsed; skin cold; pulse 64, very feeble; he complained of pain in his head and stomach, but appeared listless and apathetic; his whole body was shaken by the violent spasm, but of a curious character, as if constituted by a double paroxysm; he winced when pressure was made on the epigastrium, but he had no nausea, vomiting, nor thirst; his respiration was tranquil; tongue furred; abdomen much retracted; he was in perfect possession of his senses, and stated that his illness commenced six days previously, with severe pain in the stomach, at the time I saw him he was evidently sinking, and died in a few hours. *Post mortem* examination revealed acute inflammation of the pleura covering the right side of the diaphragm, evidenced by great vascularity and effusion of lymph; there was slight vascularity at the cardiac orifice of the stomach, so that I have no doubt but that this was a case of diaphragmatic pleurisy simulating gastritis; and it should teach us how cautious we ought to be in trusting to symptoms alone for the diagnosis of disease, for though the symptoms all indicated the stomach as the seat of the affection, yet the appearances after death satisfied me that they were merely sympathetic, and that the real disease was located in the pleura.

The case of acute gastritis, recorded by Dr. Stokes, affords a good example of the fallacy of placing too much reliance on the appearance of the tongue in diseases of the stomach, as our best observers are now agreed that there is no necessary direct relation existing between them. Andral and Louis (after extensive observations on the subject) are both agreed that "there is no modification of the one, corresponding with any special modification of the other," and we have had many opportunities of corroborating this opinion in the Meath Hospital; but I do not wish to undervalue the inspection of the tongue in disease, its condition is never to be disregarded, but it ought to be examined more with reference to the general state of the system than as an index of local disease. It is probable that in those cases when the tongue is not affected by important derangements of the stomach, it is owing to the interruption of ordinary sympathies in consequence of some powerful impression on the nervous system. On this supposition we may explain the fact, that the persistence of a clean moist tongue from the commencement is one of the very worst signs in a bad case of typhus fever, and we may regard a moist tongue with intense thirst, or a peculiarly dry tongue without thirst, as a bad omen.

CLINICAL LECTURES ON THE DIAGNOSIS OF CANCER AND CANCROID GROWTHS.

BY MAURICE H. COLLIS, M.B., F.R.C.S.I.,

SURGEON TO THE MEATH HOSPITAL AND CO. DUBLIN INFIRMARY, ETC.

LECTURE III.

Epithelioma commences on the skin as a dry and scabby wart, which falls off from time to time, and exposes on each occasion an increasingly wide surface of ulceration. At the junction of skin and mucous membrane it begins as a chap or fissure with indurated edges, and has a similar tendency to scab and ulcerate. When it originates on a mucous surface, it is either as a flat condylomatous wart, or as a deposit in the mucous follicles. Thus it is always as a local hypertrophy of the investing epithelium that it commences; and from first to last it frequently retains this strictly local character. Many of these growths upon the skin are nothing more than hard horny masses of dry epithelial cells, which occasionally fall off, and are slowly replaced. These may be either prominent or flat; we have frequent examples of them along the edge of the lip upon that part which is covered with coloured skin, external to the line of moist membrane; these are very harmless, and may last for many years unaltered in extent or depth, until accidental violence or inflammatory action excite them to spread. However in the majority of epithelial growths, ulceration of the integument and deposit of epithelial cells in its substance takes place sooner or later. The skin splits into papillæ as in a wart, and the ever increasing deposit of cells upon the surfaces of these papillæ separates them more deeply and more widely apart. As the cells are wholly extravascular, and dependent on percolation for what fluid they draw from the economy, a process of disintegration is continually going on in them, and the surface of parts not subject to evaporation is soaked in the putrid remains of cells. How far this aids in the spread of the disease by exciting inflammatory action and ulceration of the sound structures is hard to say. On mucous membranes this tendency to ulcerate is very marked; cauliflower growths from the uterus, for example, although prominent on the surface, and consisting of hypertrophies of the epithelial cells, have their seat on ulcerations which may destroy large portions of the organ. The ulcers, when exposed, present jagged irregular margins and surfaces; enlarged papillæ are visible during the early period of the disease when the surface is wiped free from discharge; at the edges they may be detected at any period. The neighbouring glands are affected irregularly; sometimes not all; sometimes at an early stage. Upon the whole, the impression on my mind is, that the tendency to infect neighbouring glands is greatest when the disease has its seat on the mucous membrane, and least when it is on skin; but no positive rule can be laid down at present as to the local infection. General infection must be extremely rare, for those who oppose the classification into cancer and cancroid can bring very few satisfactory cases of general poisoning from genuine epithelioma. The disease often kills by local destruction and general waste, but without anything which can be called special or peculiar cachexia. When removed, even completely, it will sometimes return in an aggravated form and with rapidity; but this is quite exceptional; in the majority of cases in which the disease is removed completely, it either does not return, or does so only after a very long interval. All these facts show that there is much less tendency to general poisoning than in cancer, and justify us in classing it apart, especially as it is found to possess a different anatomical structure.

Another class of cancroid tumour, to which the general name of fibro-plastic is rather incorrectly given, includes several tumours of rare occurrence and with slightly diversified peculiarities. The fibro-plastic cell is not the special element of any tumour of a cancroid nature, but the elements of these fibro-plastic growths resemble it more than any other cell. The fibro-plastic cell is found in all lymph which is undergoing the process of organization, and is consequently often found in tumours of any kind. The class of growths to which I now allude are called by Mr. Paget fibro-nucleated, recurrent fibroid, &c. The microscopic elements of which they are composed are small and very pale, they vary in diameter from the 1.1500 to 1.2200 of an inch. They contain a small nucleus and have a tendency to become elongated into imperfect fibres, arranged in a radiating manner and little organized. There is no juice obtained from a section of these tumours; and although they bleed freely when cut, it would seem to be rather from some want of power in their arteries to contract than from the number or size of the vessels contained in them. If squeezed or torn up they break readily into little acini, which are individually remarkably tough and resistant. The minute fibro-cells appear to radiate from the point in each acinus by which it is attached to the rest. The tumour which is situated under the skin, and I believe always unconnected with it, is firm, moderately elastic, irregularly lobulated, moveable among the tissues and solitary; it does not affect the skin nor neighbouring glands, except by direct contact through the lymphatics, nor does it produce general cachexia independent of waste, as cancers do. Its strongest and most unaccountable peculiarity is its frequent and rapid recurrence after the most complete ablation, after even amputation at a considerable distance from the original seat. It invariably returns in from three to six months in the cicatrix, and requires repeated removal, which should therefore always be complete, but very sparing of the healthy tissues, and repeated early on the re-appearance of the growth.

There are many other sub-varieties of both cancer and cancroid, but as we have not met with specimens of them during the present session, we must defer the consideration of them for the present. The main features of both classes of morbid growth I have endeavoured to lay before you as fully as was consistent with brevity. I will now conclude these lectures with some remarks on the diagnosis of tumours, with a view to your guidance in the important points of operation and prognosis.

When a patient is presented to you with a tumour, you must note, first, certain circumstances relating to the individual; secondly, such properties of the tumour as manifest themselves to your senses; and thirdly, the effects of the growth upon the patient. Then comparing these with each other, and with the anatomical structure and known characters of the various growths, you will eliminate such as are incompatible with your examination, and thus arrive at what the tumour is by ascertaining what it is not. First, then, you will note such circumstances about the individual as the age, sex, history, &c. As to age, infancy and childhood are liable to acute cancer, enchondroma, and strumous swellings. Adult life is the period for all hypertrophies, such as fibrous and fatty tumours, for the cancroids and for the acute cancers in organs which are late in arriving at maturity, as the organs of generation. As the patient advances in age, slow-growing epithelioma and scirrhus become predominant. Cancer and cancroid form the vast majority of the tumours that are met with, if age be excluded from our consideration.

Sex exercises still greater influence on our diagnosis. When we glance at statistical tables, we find that cancers of the female breast and of the uterus surpass in numbers all other tumours in all situations put together. Of these, scirrhus of the breast and uterus form the bulk. We have a small proportion of acute cancer of the uterus, and smaller still of the breast. Women are also subject to innocent chronic mammary tumours of the breast; both sexes to epithelioma of the rectum and genitals; and men more than women to epithelioma of the lips and face generally. As regards temperament and appearance, thin, sallow, unhealthy-looking people are supposed to be more subject to cancer; but the lardaceous variety shows that the fattest people are not exempt from it. A melancholy, brooding disposition is often connected with cancer, as it is with any disease of perverted or deficient nutrition; but, on the other hand, to whatever amount cheerfulness of temper may be an item in favour of recovery after operation, it is little protection against the primary development of disease. There are sufficiently numerous and remarkable cases on record of both cancer and cancroid occurring in successive generations, to prevent our denying the influence of their hereditary transmission; but, at the same time, these are few in comparison to the total number of cases. I have seen curious and marked instances of the repetition of encysted tumours, which have just as much weight for hereditary influence as the facts adduced in its favour in the case of cancer. Accidental violence is in much the same category; it may give an impetus to a latent tendency, and a locus to the deposit, but no more. It seems to me very doubtful whether the statement is correct, that the adenoid or chronic mammary tumour has its origin in effusions of blood.

We now come, secondly, to the properties of the tumours themselves. On this point I have said much that need not be repeated. The situation, size, weight, shape, and mobility or fixedness of the tumour; its duration and rate of progress; the colour and alterations of the integuments; the appearance of the ulcer, if one exist, and the nature of the discharge; the solitary or multiple nature of the tumour; glandular irritation or infection in the neighbourhood or at a distance—must all be carefully examined into and weighed. Acute cancer is rapid, and attains often a very large size, is heavier than any non-cancerous growth, is seldom multiple, implicates in time all neighbouring structures, though it seldom poisons the glands when primary; and it almost always returns rapidly and extensively in the glandular and visceral organs after removal. Adenoid tumours are much smaller, very chronic, very moveable, perfectly harmless, and never affect the glands or the system, though they are sometimes multiple in the same breast or in both breasts. Scirrhus is small, chronic, of stony hardness, drawing in the skin, and all the fibrous tissues, into itself, and finally the muscles, and every other structure. Cancer in any shape does not ulcerate early. This distinguishes it from epithelioma, as the preceding symptoms do from adenoid, fatty, or fibrous tumours, and from the recurrent fibro-nucleated. Fatty tumours are easily known by their lightness, and largely lobulated surface and scalloped edge. The most puzzling of all in its physical characters is the cystic tumour of the breast, when combined with cancer, as it frequently is. Except in the plainest cases, it is impossible to diagnose by the hand and eye. The presence of cysts may be readily detected in many instances, in which the cancerous deposit is small in amount, and veiled by the fluid contents of the cysts; and, on the other hand, the deposit of cancer may conceal the presence of cysts. Alterations of the integument, and the general symptoms, must guide us to the discovery of cancer; and, in the other case, if we are sure of the presence of cancer, we need not be so careful to diagnose the co-existence of cysts. I have seen simple ,cysts, the result of varices, mistaken for small fatty growths, and I really do not know any certain means of diagnosing them; but, fortunately, a mistake would be of no practical importance, as both tumours are harmless. To overlook cancer, in combination with cysts, would be more serious.

The last points to be considered in aid of our diagnosis are the effects of the growth upon the individual: these are, pain, cachexia, wasting. Pain we have already spoken of. Cachexia is of value in the diagnosis of tumours, if it appear before they ulcerate, as it generally does in cancers. In other diseases, inclusive of the cancroid, it does not appear until the patient is worn and wasted by discharge and loss of blood, by deglutition or absorption of foul matters, and inhalation of noxious gases, the results of ulceration and decomposition. Wasting may be included in these remarks on cachexia.

With regard to operation. Encephaloid is more often removed with temporary, or even permanent success, than scirrhus, but success is very rare, and when it returns it is with extreme violence. In the young, you will give every chance by removing early and freely. A respite of years, if not a recovery, is in a few cases secured; and where a premature and horrible death is otherwise certain, the duty of endeavouring to secure this chance is plain. In the old, or even in the adult, you have less hopes of success; still, operation is justifiable and proper, when the powers of life are not depressed, and the tumour easy of complete removal, without such loss of integument as will delay recovery from the operation. Scirrhus, though often removed, is not often, if ever, permanently cured. When it is adherent to the deeper parts, when the lymphatic glands are the seat of deposit, when the glands of the skin are the seat of small disseminated beads of cancer, or when its interstices are infiltrated, as in the lardaceous form, it is worse than useless to operate; relapse is certain and rapid. When the growth is very chronic and very small, in a weak atrophied individual, the chances are, that an operation will convert into an active agent of destruction a comparatively harmless tumour, which, if let alone, would have lasted for years, with little local alteration, and little injury to the patient's life. In these very chronic cases, removal does no good, and may do much harm. In epithelioma, the general rule is to operate if you can remove all; relapse often occurs locally, but does not prevent a second or third removal. When the disease originates in mucous membrane, as in cancroid of the genitals or rectum, the tongue, or gums, you have little chance of permanent cure. In many of these cases, the addition of actual cautery to as complete removal as possible is a valuable aid. The cicatrix of a burn is not a favourable nidus for epithelial growths, and by its great contractility it seems to check the hypertrophic deposit in its neighbourhood. With regard to recurrent tumours, I have already said they must be removed as often as they appear, and with as little loss of healthy structure as is consistent with their complete enucleation.

I now conclude these lectures, into which I have endeavoured briefly to collect such facts as are well proved in connexion with cancer and cancroid growths. They are necessarily very imperfect, but they will, I hope, serve as a guide to you in your reading. The subject is one over which theory has had full liberty to ramble; and there is scarcely one among the many valuable treatises upon it, the utility of which is not marred by the admixture of fancy and speculation. Let our habit be to study nature closely, and note well her operations, and to be guided by them in our practice.

Compound Fracture of the Tibia; extensive Flesh Wound of inner Side of Thigh; secondary Amputation; unusual Morbid Appearances on Examination after Death.

[To Mr. Joseph C. Wright, Assistant-Surgeon, Royal Artillery, Crimea, we are indebted for the following interesting case of gunshot wound, which occurred in the practice of Mr. Howard, Surgeon of the 20th Regiment]:—

Henry Penyer, ætat. 21 years, of stout make, light hair and eyes, and sallow complexion, of temperate habits generally; came out to the East in July, 1854; suffered from the prevailing camp dysentery during the winter; was two months at Scutari, and since then had been uninterruptedly at his duty. On the night of July 25th, was wounded while in the trenches by a grape shot, thrown from a mortar (vertical grape), striking him upon the inner side of the right thigh, about four inches above the knee-joint. The missile carried away a large superficies of skin, and passing downwards, the leg being somewhat bent at the time, fractured the head of the tibia; the joint was not opened. The bone was extensively injured, being penetrated by a number of longitudinal fissures at the seat of fracture, whilst the fragments were so little displaced that the patient himself was able, by his own efforts, to straighten the limb; under these circumstances, the fragments lying so closely together, the joint not being opened, and the fibula uninjured, it was thought right that an attempt to save the limb should be made. Accordingly the leg was slightly flexed and laid upon the outside; and as soon as the man recovered from the shock of the injury and the immediate effects of a large hæmorrhage from the saphena vein, which had been lacerated, water dressing was applied and kept moist by a continuous dripping from a vessel suspended above. A full opiate was administered, and he passed a quiet night and slept soundly.

On the following day all oozing of blood from the denuded surface had ceased, the posterior tibial artery was felt firmly pulsating at the inner ankle, and the whole limb was of natural temperature.

27th July. Passed a tolerable night, free from pain in the limb, but diarrhœa had supervened to the extent of five large evacuations of bilious and feculent matter; some increase of swelling of the limb, but no great tension of the parts, owing, perhaps, to the skin above having been so extensively removed. On examination, several fragments of the tibia were found more moveable, but as the attempt to remove them occasioned much pain it was desisted from, and the irrigation continued.

28th July. Increase of suppuration and fœtor from the wound over the tibia; the portion of the thigh from which the skin had been stripped looked healthy, and but little sloughy; wounds thoroughly cleansed with a weak solution of chloride of soda, and some small fragments of bone removed.

29th. Same report; appetite tolerable; bowels still loose.

30th. Suppuration increased; a large piece of bone removed, leaving a large cavity, the sides of which were sloughy and secreted pus of thin consistence and fœtid odour; wound cleansed as before; the irrigation was omitted, and a large poultice enclosed in linen applied over the whole limb from the knee; the pulse was more rapid, and there was some transient delirium during the night; bowels again too free, five or six stools passed during twenty-four hours; wine (8 oz.) was added to his diet, and the opiate continued at night.

31st. Bowels not so relaxed; pulse, 100; no appearance of any improvement in the cavity in the head of the tibia; the fissures between the fragments, which previously were scarcely displaced, are now much widened.

Aug. 2nd. Pulse, 110; suppuration increased; aspect depressed; face pallid, and has not slept; amputation above the knee decided on, because, although the knee-joint remained intact, yet the injury to the tibia was so severe, and the hiatus in the cancellous structure so great, that at this season, owing to the heat, there was great danger to be apprehended from the constitutional effects of the injury. Accordingly the limb was removed at the junction of the lower and middle thirds of the femur by an anterior and posterior flap. The hæmorrhage during the operation (performed under chloroform) was trivial; the femoral and another artery (one of the perforating) only required ligatures; though warm water and the removal of all compression by the tourniquet was resorted to, in order to ascertain if any more vessels were disposed to bleed. Such, however was not the case, and the flaps were merely laid together, and retained by a Maltese cross of linen, well wetted, and by two or three turns of a circular bandage; when the patient was removed to bed, precautions were taken against hæmorrhage, by the application of a tourniquet loosely round the thigh, and the constant presence of an attendant.

3rd. Five sutures were introduced into the edges of the flaps, and a bandage and water dressing lightly applied to the stump, which was supported on a pillow; pulse 98; tongue moist; bowels quiet; had slept several hours.

4th. Stump easy; no swelling; bowels natural; slept well; pulse 90; reddish serum oozing from between the sutures.

5th. Spirits good; pulse 96; slept; bowels three times moved in twenty-four hours; stump slightly swollen, with some increase of purulent discharge from the wound; patient's manner is sharper, and a peculiar anxiety is visible in his face.

Haustus morphiæ statim.

At 5 P.M., patient was seized with an intense rigor; pulse became small and excessively rapid; respiration correspondingly affected; the bowels had been twice purged since morning, but not profusely; tongue chilled, and surface below the natural temperature generally; he was covered with additional blankets; some warm wine exhibited, and hot water baths applied to the extremities and axillæ. This state of depression lasted two hours and upwards, when the pulse gained volume, and he was directed to take the following:—

℞. Antim. tartratis, gr. i.
Tinct. opii ʒi.
Liq. ammon. acet. ℥ii.
Aquæ ℥vi.
Sumat unciam tertiâ quâque horâ.

12 o'clock *Midnight.*—Sweating profusely; pulse 140; respiration rapid; and some mucous rale heard on both sides of the chest, loudest on the right side; did not desire to be raised from the recumbent posture; shortly after his wine fell asleep, breathing loudly, but readily aroused.

6th. Pulse reduced in frequency to 100; intellect quite clear, but there was a tendency to insensibility; the mucous rales in the large bronchial tubes were more audible, and he lay quite supine in bed; the antimonial and opiate draughts had been discontinued since the previous midnight, and he had taken small quantities of rice water and essence of beef.

11 A.M. Pulse failing; mucous rales louder;

movements of respiration short and spasmodic; and he appeared dying from asthenia and slowly approaching asphyxia; and at about 1 P.M. he had ceased to breathe, the neck and face becoming congested previously to the final cessation of the heart's acton.

Examination twenty-three Hours after Death.—The body, which had lain on a stretcher under a hut, was everywhere emphysematous from evolved gases; countenance quite obscured and face livid; deep arborescent venous congestion of integument of chest; central portions of belly free from this appearance; scrotum enormously distended; abdomen tense; left lower extremity emphysematous; stump gaping; on opening it up, there was found soft adhesion at the outer side; the end of the bone for an inch and a-half was whiter than natural, and the periosteum easily scraped off; the artery was occluded at the seat of ligature, and reddened above for an inch or more; the femoral vein was closed with soft lymphy exudation; the cellular tissue was emphysematous, like that of other parts; the lungs were congested towards their bases, but no deposits of purulent matter were anywhere contained in them; their structure was friable to an extreme degree, and they broke down into an undistinguishable mass on the slightest pressure; the heart was entirely empty of blood; valves perfect.

Abdomen.—Liver so decomposed as to preserve no traces of its proper structure; the kidneys were congested; the intestines remarkably transparent; this perhaps was attributable to the pressure of the quantity of contained gas within them; the vena cava was distended by gas to a great size, and contained but very little blood; there was no trace of phlebitis in it or in the iliac veins; there was probably a depraved condition of the blood, and a tendency in it to pass into combinations, other than those fitted for the purposes of life, as evidenced by the rapid decomposition which occurred a few hours after death. This change of the nutrient fluid was perhaps in its commencement by the rigor observed on the evening of the 5th; no other lesion could be discovered to explain the great constitutional derangement that supervened upon the rigor which was so marked, and upon which death so speedily followed.

SKIN DISEASES.

From the French of M. Maurice Chausit.

BY T. K. BARTON, A.B., M.B., T.C.D., &c.

(*Continued from page* 229.)

Sycosis is a malady so frequently met with in this country, so annoying to the patient, and withal so often difficult of cure, that we gladly transcribe the principal part of M. Chausit's observations on this disease. Some, doubtless, will be surprised at the summary manner in which he dismisses the good old theory of contagion from a dirty razor. He defines the disease to be: "An inflammation of the skin, characterized by little pointed pustules, which suppurate incompletely, scattered over the chin, the upper lip, the cheeks, and the submaxillary region, to which succeed tuberculous indurations, sometimes so considerable as to disfigure the countenance."

Sycosis presents in the course it pursues, and in its symptoms, some curious characters, which render this disease of considerable interest to the practitioner; thus it but very rarely exists in an acute state, such as is constituted by an eruption rapidly developed, and terminating in a few days. Most frequently it presents itself in a chronic form, but with this peculiarity, that it consists of a series of eruptions, which exist sometimes in an acute, sometimes in a chronic state, and pass from one into the other with such rapidity, as to prove a real source of difficulty in the treatment.

Sycosis is developed and continued in a manner we might call insidious. At first it consists of a number of pimples (*boutons*) either upon the upper lip, chin, or submaxillary region; these, accompanied by a little redness and heat, become pustules, generally discreet, pointed, suppurating incompletely, and replaced soon by little crusts which fall off in six or seven days; these first symptoms of sycosis generally pass without the patient making much complaint. The eruptions, at first at considerable intervals from one another, become more frequent, and at the same time more intense; each one is accompanied and preceded by a marked sensation of heat, tension, and even of pain. The pustules are protuberant, although of different sizes; they suppurate incompletely, give exit to a yellowish pus, and are always traversed by a hair. They become more persistent, giving rise to thickish brown crusts, which, when thrown off, remain attached to the hair, leaving in their place a depressed spot.

When the disease continues it is by successive eruptions, not by a continued secretion as in impetigo. According as the crops of pustules become more frequent and more intense, the base of the pustules becomes thickened, forming in some places two indurations traversed through the centre by a hair; it is these that have caused sycosis to be named a tubercular affection. This phenomenon is, however, to be attributed to the persistence and extension of the inflammation, which, extending by degrees, engages one after the other the different layers of the skin; finally getting down to the cellular tissue, it causes these tubercular indurations, which gives to sycosis its peculiar secondary physiognomy. When the disease has arrived at this stage we see even the whole surface which the sycosis occupies, but chiefly in the submaxillary region, tuberculous indurations, true nodosities, varying from the size of a nut to that of a hen's egg. These indurations are red and shining, and are sometimes so numerous as quite to distort the countenance. This state of sycosis does not, in general, exist except after a long continuance of the disease, although cases are recorded in which sycosis has passed rapidly into the tuberculous state, a circumstance important to be remembered, as it bears directly on the nature and prognosis of the disease.

The inflammation occasionally extends deeper still, and gives rise to abscesses, most frequently when it is very persistent; it attacks the hair-bulbs, which causes the hair to fall out rapidly; the baldness which follows is, however, but seldom lasting, generally when the disease gives way the hair springs up again.

The extent of the eruption is very variable; it sometimes occupies every point over its seat of election, but again it is sometimes very limited. M. Cazenave has observed it confined in the upper lip, to the furrow beneath the nasal septum. The duration of sycosis is very variable. When it becomes chronic it is always of very long and obstinate continuance; when it is giving way the tubercular indurations become flattened and then disappear; the pustular eruptions become more and more rare, leaving after them for a time a slight epidermic exfoliation.

The Causes of sycosis may be divided into the general or predisposing, and the local or existing.

Amongst the former are, first, the male sex; for sycosis is a disease peculiar to the beard, and, consequently, does not exist except amongst men. The adult age, a bilious, a sanguine temperament, a particular susceptibility of skin, excess of nourishment—in fine, a peculiar idiosyncrasy, which must account for the disposition which certain individuals have to be affected by this disease, and for the frequency with which it returns.

The local causes are certain employments, such as founders of metals, cooks, &c., from being exposed constantly to the rays of a hot fire. On the other hand, the influence of cold seems to excite it; habitual want of cleanliness; finally and chiefly is the irritation arising from the constant use of the razor. This last circumstance has given rise to the idea that sycosis is contagious, and is propagated by a dirty razor; but this is an hypothesis unsupported by any well ascertained facts. Sycosis is not contagious.

The Treatment of sycosis presents, in practice, considerable difficulties, arising from the tendency of the eruption to pass rapidly from a chronic to an acute state; and from the possibility, if not the frequency, of the return of fresh inflammation, the practitioner should never lose sight of this important circumstance, which will so much affect the treatment. First of all, it will be necessary to remove or avoid the causes which tend to produce the disease, such as errors of diet, exposure to a hot fire, and the use of the razor. We would advise, in all cases, the beard to be cut with scissors. When sycosis presents itself in the acute form, and during the inflammatory period, it will be necessary to insist upon the antiphlogistic line of treatment, to consist in the application of leeches behind the ears; or even bleeding from the arm, if the patient be young and strong, is useful in the beginning. We would advise, too, refreshing drinks and a mild diet. Locally, we employ emollient fomentations, cataplasms of the fecule of the potato, and infusion of marshmallows (*althæa officinalis*); we insist especially upon the use of this last, while the inflammation lasts. When sycosis exists in, or has passed into the chronic state, when all trace of local inflammation has ceased, and it is decidedly in the tubercular stage, it becomes necessary to have recourse to resolvent means more or less active. We have obtained good results from alkaline douches, and from the steam douches, administered at the temperature of 30° to 32° of Reaumur, for ten minutes. We have also found useful an ointment of the ammoniacal protochloride of mercury, or the iodide of sulphur, in the proportion of ʒss. to ℥i. of lard. This should be rubbed on at night, and in the morning the diseased surface washed with an alkaline solution (bicarb. potassæ, ʒi.; aquæ distil., ℥xvi.) We consider that it is only in the alternate employment of these different means, according as the eruption is in an acute or chronic state, that a certain and rapid success can be gained in the treatment of sycosis. This treatment will be greatly aided by the employment, when they are required, of laxatives, of calcined magnesia, or the sulphates of potash or soda, or by the administration of the waters of Vichy.

It has been proposed to employ cauterization for the cure of sycosis; but M. Cazenave has rejected this as quite inadmissible, inasmuch as the remedy, if it is at all effective, is worse than the disease. Counter-irritation also should not be employed in the treatment of sycosis, as it tends so excite what we should seek to avoid, viz., a return of the acute state of the disease.

SELECTIONS FROM BRITISH AND FOREIGN JOURNALS, &c.

Case in which the Eruption of Pompholix was simulated.

M. Bazin, of the *Hôpital St. Louis*, contributes a case in which a young woman produced a succession of crops of bullæ by means of the powder of cantharides. The imposture was not detected for several months. The eruption, it was stated, first commenced in 1852, got well, and again appeared in 1854.

She was admitted into Saint Louis February 13, 1855. Bullæ then existed on the eyelids, lips, mammæ, abdomen; an erythematous redness surrounded the bullæ. Up to March 10 the affection seemed to get worse, and the bullæ came out in successive crops in great numbers. During this period the patient had two slight attacks of what appeared to be cystitis, the cause of which was not very obvious, but which afterwards was sufficiently accounted for. On the 21st April, on one of the bullæ which had come out during the night, *brilliant green scales* were observed. These, when examined, were recognized as being cantharides powder. When asked what they were, the patient got very red and uneasy, and endeavoured to rub them away. She then said they must be part of the ointment which she had been using; but the ointment was examined, and found to be free from any similar substances.

In all respects the case presented the characters of acute pompholix, except that constitutional symptoms were not observed to precede the eruptions of bullæ.

In a similar case mentioned by Rayer (*Traité des Maladies de la Peau*, Art. *Vésicatoire*), the patient had got possession of some powdered mustard, by means of which the redness around the bullæ had been produced.—*Gazette Medicale.*

Utility of Quinine in Strumous Ophthalmia (Scrofulous Keratitis).

M. Madri (*Presse Medicale Belge*) reports very favourably of the beneficial effects of sulphate of quinine in this troublesome affection, the introduction of which into practice he attributes to Mackenzie. Under its use he always finds the *photophobia* to cease, and the ulcers of the cornea to heal up. Before the quinine is given, leeches and purgatives, he says, are to be given.

The reporter in the *Gazette Medicale* says, very rightly, there is nothing new in this practice, Mackenzie and Travers having already recommended it, whilst Rognetta, we learn, in his *Traitè d'Ophthalmologie* (1844), gives it the highest praise; but that credit is due to M. Madri for confirming by his own practice the opinions of these authors.

[The following cases (briefly detailed) are remarkable illustrations of the fact that wounds of the stomach are not necessarily fatal. Of their value in a practical point of view we are more dubious. Heroic surgery now-a-days is surely in no need of encouragement.]

CASE 1.—*Gastrotomy successfully performed for the Removal of a Bar of Lead from the Stomach.* By DR. JOHN BELL, of Wapello, Iowa.

On Christmas day, a man came to Dr. Bell's office, who was said, while performing a favourite feat of running a bar of lead down his throat, to have accidentally let it slip, and that it had descended into the stomach.

The man asserted that he had swallowed the bar, and added, "that it was nothing wonderful, as he had swallowed three or four bars at previous times."

As the man was partially intoxicated, and had, moreover, the reputation of being an expert juggler, Dr. Bell came to the conclusion that it was a hoax, but, to satisfy himself further, passed a sound down the œsophagus, but did not discover anything.

On January 9th Dr. Bell was hastily summoned, and found the patient suffering from gastralgia and abdominal soreness. There had been considerable retching, and vomiting of a dark watery fluid; pulse small and quick, great anxiety, restlessness, prostration, and apparent sinking of the vital powers. Next day gastrotomy was performed.

Chloroform was administered; at first it produced vomiting, and the patient threw up a quantity of black, fœtid fluid. As soon as anæsthesia was produced, an incision was made from the point of the second false rib on the left side to the umbilicus, dividing all the parts to the peritoneum, which latter was opened up by a blunt-pointed bistoury. The bar was now felt lying transversely within the stomach. "As it was impracticable to reach the upper end," Dr. Bell says, "I seized the bar between my thumb and middle finger, and, with the fore finger on the lower end of it, I retracted it upward and backward, for the purpose of making the incision in the stomach as high up as possible. I then passed a scalpel in along the side of the fore finger, as a guide, and divided the coats of the stomach immediately at the end of the bar, making the incision parallel with the muscular fibres (?) and not larger than to admit of the removal of the lead."

This was effected readily with a pair of long forceps, and the wound closed with sutures and adhesive straps.

No bad symptoms, and on the fifteenth day after the operation the patient had completely recovered. The length of the bar was 10½ inches; its weight, 9½ ounces avoirdupois.—*American Journal of Medical Science.*

CASE 2.—*Wound of the Stomach; Recovery.* By C. H. HAPPOLDT, M.D.

Thomas Anglissy, æt. 17, received, February 10th, a wound from a bowie knife, which entered at a spot three inches to the left of the middle line between the ensiform cartilage and umbilicus. The contents of the stomach escaped through the external orifice.

The wound was carefully closed, a compress and bandage applied to prevent muscular contractions, and the twelfth of a grain of sulphate of morphine given every two hours. Next day there was fever, tympanitis, and emphysema of left side of trunk from the clavicle to the pubis; the wound gaped, and gas escaped from it. On the fourth day the fever had abated, emphysema had not extended; bowels had not been freed since accident, so an enema was ordered. Sixth day.—Half-a-pint of offensive pus flowed from wound; fluids taken by the mouth do not escape by the wound. Seventh day.—All fever gone; emphysema diminishing. Eleventh day. — Wound closed; circumscribed induration remains behind. He soon was perfectly well, and resumed his occupation as a sailor. A month afterwards matter formed again in the seat of the wound, and pus was discharged for three days. Perfect recovery ensued.

Case 3.—[In this case, which occurred in the practice of a Spanish physician, Dr. Francisco Garcia y Garcia, of Daimiel, a foreign body of considerable size accidentally got into the stomach. Life being in danger, gastrotomy was proposed, but the patient refused to give his consent; nevertheless, the unaided powers of nature brought about a successful termination of the case. The foreign body, which consisted of ten inches of a thick stick, was got rid of by a process of ulcerative absorption.]

The patient, who was about fifty years of age, was affected with syphilitic ulceration of the fauces. His attending physician directed that the parts should be cleansed several times daily; and for the purpose constructed a swab, with which he made the first applications; but, as it was not sufficiently long, the patient had it spliced, until the stick was more than ten inches in length. On one occasion, whilst using this instrument, we are told that the stimulus of the medicament, the contraction of the muscles of the pharynx, a spasmodic movement, the carelessness of the patient, or all conjoined, caused him to relinquish his grasp of the instrument, which passed into the pharynx. For a short time he was in great distress, and on the verge of suffocation, but at last the stick descended into the stomach. Eight days afterwards, severe pains were felt in the stomach, accompanied with gastric irritation and febrile symptoms. In a day or two the greater part of the gastro-peritoneal symptoms, which indicated great peril, abated. As the stick could now be felt in the stomach, gastrotomy was proposed. The patient refused his consent.

Ten days afterwards, a swelling like an anthrax had formed below the nipple on the left side. It was opened by a crucial incision. Four days afterwards, a female neighbour, who was present to assist him, saw with wonder the end of a black stick in the opening of the abscess. Encouraged by the patient, she seized the foreign body, and drew out four or five inches of it. Dr. Povil now came, and not without some difficulty extracted all the stick through the intercostal space between the third and fourth false ribs of the left side (!) The extraction was followed by a flow of pus, considerable blood, and gastric juice through the wound, together with some partially digested alimentary substances which had been eaten in the morning. In twenty-six days the wound was completely healed.

On Mothers' and Nurses' Milk. By Dr. Herm Ploss.

Dr. Ploss's 'Memoir' is an interesting contribution to a subject in which our knowledge is very defective: namely, the variations that take place in the constituents and nutritive properties of human milk.

The water is increased by improper food, bad digestion, and in a peculiar manner in so called strong constitutions. The child falls off, becomes anæmic, and its nightly cries indicate unsatisfied calls for nutrition. With this condition there is much urine, and scanty stools. The water is diminished by recurring pregnancy during menstruation, by intervening illness, especially by acute colitis, and chronic enteritis. A diminution of solid food and increased imbibition of water are recommended; and if pregnancy occur, weaning.

The solid elements are increased under the conditions just named, as in colitis. The milk becomes too nutritive, and difficult of digestion. There is diminution of the solid elements when nourishment is bad, in advanced age, typhus, and in chronic tuberculosis, without diarrhœa.

Casein appears increased in much developed breasts, menstruation, acute disease, and mental disturbance. The child soon suffers from constipation, aphthæ, and lastly, marasmus. The casein is diminished when nourishment is bad, in robust constitutions, chronic diseases, typhus.

The butter is increased in much developed breasts, pregnancy, acute, and still more in chronic disease. In this case also the nutrition of the child is gradually impaired. The woman should take free exercise in the open air, and a diet as free as possible from amylaceous and fatty materials; the child should take the breast more sparingly. The butter is diminished when nourishment is bad, in mental commotions, and tuberculosis with diarrhœa; here an amylaceous and fatty diet is useful, and bodily and mental quietude.

The sugar is but seldom increased. It is diminished by absolute fasting, in robust constitutions, during menstruation, and in acute diseases. This deficiency may be supplied by administration of milk-sugar to the nursling, whilst the nurse may take amylaceous and saccharine diet.

The salts are increased in acute disease, especially typhus, and these occasion diarrhœa in the child; they are dimished in chronic diseases, especially in those of the intestines. Both nurse and nursling should take phosphate of lime and common salt.—*Journ. f. Kinderkrankh.* and *Med.-Chir. Rev.*

A Contribution to the Doctrine of so-called Paralysie Musculaire Progressive. By Dr. THEODOR VALENTINER.

The term paralysie, or atrophie musculaire progressive, was applied by Cruveilhier to cases of fatty degeneration of the muscles, resembling those detailed by Dr. Meryon,* in which no essential morbid change could be traced in the nervous centres;† but in which the gradual and entire loss of power of certain sets of muscles, accompanied, as Duchesne had pointed out, by loss of electric excitability, constituted the main symptoms, while both naked eye and microscopic examination demonstrated a complete fatty degeneration of the affected muscles. Dr. Valentiner's case is of considerable interest; we can only give it in a much abridged form. It will be seen that the primary lesion in this instance appears to have been in the spinal cord.

A gentleman, aged 45, of robust and athletic habit, and peculiarly gifted, had always enjoyed good health, and although he had occasionally committed excesses in his cups, was generally temperate, and remarkably fond of gymnastics. Ten years previously he once fell on his back, on a sandy soil, from a height of eight or ten feet. About two years after this the patient, who had experienced no inconvenience at the time of the fall, thought his health failed; his florid complexion became sallow. A year later, in 1847, he had a slight attack of pleurisy; but as late as 1852 he could have experienced no great diminution of physical strength, for he was still able to carry two fifty-pound weights in each hand. In April, 1853, he first consulted Dr. W. H. Valentiner, who found that he had then very little power in his hands; that he was unable to exert any possible compression or stretch out his fingers completely; the right hand was the weaker of the two; no emaciation was perceptible; there was a difficulty about all the movements of the body, and the patient had a difficulty in carrying the food to his mouth; no tenderness or change of any kind was perceptible in the skin; no central affections could be traced. The various physicians consulted regarded the affection as one of the nervous system, without being able to realize it. The patient was sent to Frangensbad a watering place, were he used the baths, and then went to Nancy in the south of France. Dr. T. Valentiner (the author) was now consulted, and having become acquainted with Cruveilhier's cases, diagnosed the present one as an instance of fatty degeneration of the muscles, with atrophy of the anterior roots of the spinal nerves. In the autumn of 1853, though the paralysis became more and more marked, some hopes were excited in the patient by the occasional occurrence of sudden and frequent twitchings in the affected muscles. In November the patient was conveyed back to his home; he then exhibited extreme emaciation of the upper extremities; none of the limbs could be properly extended; in an attempt at walking the feet dragged on the ground; his back was almost bent double; the face, though already showing symptoms of paralysis, still retained its intellectual expression; sensibility continued unimpaired in all parts of the body. At last dysphagia supervened, and although the appetite continued good, the paralysis progressed, and a slight attack of bronchitis, in March, 1854, terminated the patient's misery.

The following are the main results of the *post-mortem* examination:—The deltoid and other muscles of the upper and fore-arm had almost disappeared; the muscles of the hands were entirely converted into fat; the muscles of the cervical and lumbar regions presented a tolerably healthy appearance, but in the dorsal region they were pale, and traversed by yellow bands; and one fasciculus closely resembled fat. The microscope confirmed the various degrees of fatty degeneration observed by the naked eye. The muscles of the lower extremities were in a healthier state than those of the upper. On slitting up the entire dura mater of the spinal cord, about one hundred small white bodies were observed scattered over the dorsal surface of the cord, exclusive of the cervical portion, varying in size from a pin's head to a small pea, smooth externally, rough on the inner side, and grating under the knife; under the microscope they exhibited a dense fibrous tissue interspersed with pigment. All the anterior roots of the spinal nerves were distinctly thinner and smaller than the posterior roots, flabby, resembling a tissue filled with a reddish serum, and exhibiting under the lens a marked vascularity; healthy nerve-fibres were still visible under the microscope, but many were in a state of fatty degeneration. Nothing of the kind was found in the posterior roots; the cord was found abnormally at the part where the three lower cervical and four upper dorsal nerves are given off; at this part the distinction between the grey and white matter was almost effaced; numerous glomeruli (granular corpuscles) were found in the softened part; they occurred in the white as well as in the grey substance. Scarcely any well marked ganglionic cells were discoverable in these parts, but were found in the unsoftened portions, lower down; no marked lesion could be discovered in the brain; the heart healthy to the naked eye, showed under the microscope incipient fatty degeneration; much oily matter was contained in the hepatic cells; the nerves of the brachial plexus exhibited no abnormalities; excepting congestion of some parts of the lungs and slight pleuritic adhesions at the right apex, no other visceral lesion was discovered.

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* Medico-Chir. Trans. vol. xxxv. p. 73.

† In one of three cases detailed by Cruveilhier, there was atrophy of the anterior roots of the spinal nerves.

The author of the paper is of opinion, and it would appear that he is fully borne out in the view, that chronic arachnitis, first caused by the fall, was the fundamental lesion in the case just detailed, and that the atrophy of the nerves and the fatty degeneration of the muscles, were consecutive. It is curious that considering the site of the arachnoideal formations, there should have been no loss of sensibility.—*Vierteljahrschrift für die Praktische Heilkunde* and *Med.-Chir. Rev.*

Abstract of the Report of the Committee of the Academy of Medicine on Catheterization of the Air-Passages.

[We copy from the New York *Journal of Medicine* the following very interesting report on an operation of considerable importance, and as to the much vaunted success of which we have long entertained great misgivings.

The great results which we have been led to expect, and the numerous cases *of recovery* which have been recorded, in consequence of this novel mode of treatment, rendered the appointment of this committee almost a matter of necessity; and we feel that we owe much to the great patience with which they have made their investigation, and the highly lucid manner in which they have conveyed their report.]

This Committee was appointed to report upon a paper read before the Academy of Medicine, by DR. HORACE GREEN, "*On the Employment of Injections into the Bronchial Tubes, and into Tubercular Cavities of the Lungs.*" The committee consisted of Prof. WILLARD PARKER, *Chairman*, Drs. ALEX. H. STEVENS, ISAAC WOOD, J. ANDERSON, J. T. METCALFE, B. F. BARKER, and JOHN O. STONE. The following is an abstract of the majority report.

The committee met on five different occasions. At these different meetings 38 patients, in the aggregate, were submitted by Dr. Green and others to the test of the operation of passing instruments into the air-passages, and three, of the injection of nitrate of silver into these passages.

I. *As to the Practicability of the Operation of passing Instruments into the Air-Passages.*

This division of the Report was considered under the following heads:—

1. *History of Catheterism of the Air-Passages.*—The introduction of tubes into the air-passages is not a recent operation. It was recommended by Hippocrates, and seems to have been long practised in preference to bronchotomy. Desault, among modern writers, also recommended it strongly. Mr. Ryland, in his treatise on *Diseases of the Larynx*, devotes a short section to this operation. Other authors allude to it as a matter of history.

2. *Results of Experiments.*—The results of experiments confirm the records of history, as to the practicability of the operation of catheterizing the air-passages. In 11 cases it was performed to their entire satisfaction. The evidences on which they rely as proofs of its success are:—

1. *The detection of the tube in the cavity of the larynx by the finger passed into the mouth.*—This was done by several of the committee, and was demonstrative of the position of the tube in relation to the laryngeal openings.

2. *The symptoms manifested by the patient.*—

The symptoms which distinguish the passage of an instrument into the trachea and œsophagus may be thus contrasted:—

TRACHEA.	ŒSOPHAGUS.
1. Suffusion of the face, rapidly increasing to turgescence and lividity.	1. Suffusion of the face slight, rapidly subsiding with cessation of retching and vomiting.
2. Great anxiety and alarm; not easily pacified.	2. Little anxiety; easily pacified.
3. Eyes wild, staring, overflowing with tears.	3. Eyes natural; slight suffusion from tears.
4. Cough violent and spasmodic.	4. Little or no cough.
5. Respiration greatly disturbed; inspiration loud, hoarse, and croupy; expiration attended with violent cough, ejection of bronchial mucus through the tube, and finally full breathing, through the instrument.	5. Respiration little, if at all disturbed; occasional puffs of air through the tube.
6. Voice extinguished, a hoarse whisper, interpreted with difficulty.	6. Voice distinct; often quite natural.
7. Retching slight.	7. Retching and vomiting a common symptom.

So prominent and characteristic are the symptoms which the patient manifests on the successful introduction of the instruments into the air-passages, and so strikingly do they contrast with those witnessed when it enters the œsophagus, that the committee came to regard the rational signs as the surest criterion of the success of the operation. In but a single instance did they fail of being exhibited with characteristic intensity. In this case the patient had suffered from a syphilitic ulceration of the air-passages, and to this circumstance, together with his enfeebled condition, was attributed the absence of the severe symptoms. Dyspnœa and lividity of the face were the only evidences of the success of the operation. They therefore establish it as a rule, to which ordinarily there is no exception, that the rational signs above tabulated will differentially distinguish the course which the instrument takes, whether into the laryngeal or œsophageal passages.

Other tests were employed, but none of them were found, on trial, free from objection.

The power of the patient to blow out a lighted candle, and to collapse and inflate, at will in respiration, a bladder attached to its free extremity through the tube, has been much relied upon as a proof that the tube had entered the trachea. But it was found that when the tube was purposely passed into the œsophagus, this power was still retained, though in a much less degree.

The passage of two sponge-armed probangs into the throat, and by the withdrawal of the lower one, calculating the position of the other, whether in the œsophagus or trachea, did not, as far as experimented with, yield satisfactory results. For it was not proved to the satisfaction of the committee that the sponge-probang entered the larynx and trachea.

The sensations of the patient are reliable only when the tube has been repeatedly passed both in the trachea and œsophagus. In these cases patients have very promptly and correctly decided which passage the instrument was entering. This fact was strikingly illustrated in Mary Norton, on whom the operation was repeatedly performed before she was brought before the committee. On the first and second trials of the introduction of the tube by Dr. Green, she shook her head, indicating that it had not entered the larynx. The operator, however, was satisfied on the last trial that the tube had penetrated the trachea, and that the sensations of the patient were not to be relied on, when she ejected a portion of the contents of the stomach through the tube, and thus demonstrated not only the position of the instrument, but equally the correctness of her sensation.

It appeared very evident also, in the course of these experiments, that the opinion of the operator, as to the course which the instrument takes, is unreliable, when he trusts to his own senses, and disregards symptoms. They witnessed in two cases the fallacy of Dr. Green's opinion, as to the success of his experiment, though based upon so large an experience. In both instances, while positive that he had successfully passed the instrument into the trachea, the patient vomited, through the tube, and thus demonstrated his error.

II. *Facility of the Operation.*—While these experiments proved conclusively to the minds of the committee, the practicability of passing tubes into the air-passages, they also afforded opportunities of witnessing the facility with which the operation is performed under different circumstances, and with different instruments. These were as follows:—

1. *Previous Preparation of the Patient.*—It is contended that the facility with which the instrument is introduced depends much upon the previous preparation of the patient, by frequent application of the nitrate of silver to the upper part of the larynx. To obviate this objection, the committee met twice at Dr. Green's office, to witness the experiment upon patients whom he was treating with local applications to these parts, and at the second visit at Bellevue Hospital, the patients were selected from a class which had been expressly prepared for the experiment, by the application of caustic to the throat from three to five times during the preceding week.

The results of these experiments, however, do not sustain the above assertion. The patients on whom Dr. Green had been operating for six months, more or less, were as intolerant of the actual passage of the tube into the trachea as those first submitted to trial. The case of Mary Norton was adduced. Although the tube in her case had been passed into the trachea half-a-dozen times previously to her coming before the committee, still she exhibited, in the most marked manner, all the evidences characteristic of the introduction of a foreign body into the air-passages when the tube was successfully passed.

2. *Instruments employed.*—The facility with which catheterism of the air-passages is performed seems to depend in a great degree upon the instruments used. Those employed in these experiments were: 1. A tube, consisting of Hutching's catheter No. 10, with a wire stilet, and bent with a curvature corresponding to a circle of six inches in diameter. 2. A tube of the same size, slightly bent at its extremity. This was the instrument selected by Dr. Green, and is the one which he is accustomed to use in practice. 3. A sponge-armed probang, the sponge having a diameter of one half to three-quarters of an inch. The result of the experiments with these several instruments was as follow:—

	No. of Trials.	*Failed.*	*Succeeded.*	*Per cent. Failures.*
Tube with large curve,	19	8	11	about 28
Tube with small curve,	37	34	3	" 92
Sponge probang,	18	18	0	100

From these experiments it appears that the instrument best adapted to succeed in catheterism of the air passages, is a tube having a large curve, or one shaped like a common catheter; while that least adapted to enter the trachea is the sponge-armed probang.

1. *The Tube with a large Curve.*—This instrument was introduced into the trachea eleven times, to the entire satisfaction of the committee. The fact that the operators were successful eleven times in nineteen trials proves that this tube can be introduced with considerable certainty into the air-passage.

2. *The Tube with the small Curve.*—This is the instrument selected by Dr. Green for catheterization of the air-passages, and is that which he uses in practice. In these experiments he was the only one who employed it, and the result shows that even in the hands of the most skilful practitioner, it failed of entering the air-passages in about 92 per cent. of trials.

3. *The Sponge-Probang.*—This instrument afforded the least satisfactory results of any used. Notwithstanding the most persevering efforts with the whalebone slightly bent, as used by Dr. Green, and with patients who quietly submitted to the test of experiment, the results were entirely negative. In no instance did it satisfactorily enter the trachea. In two instances, with the whalebone curved like a common catheter, the sponge was thought to have entered the larynx; but with repeated efforts it could not be passed between and beyond the vocal chords. The suffocation was so great each time as to compel a withdrawal of the instrument.

III. *The Utility of Injections into Tubercular Cavities of the Lungs.*—This portion of the report was brief. As the committee had no evidence that injections could be thrown into tubercular cavities of the lungs, they refused to discuss, on merely theoretical grounds, the question of their utility. One of the three cases injected with nitrate of silver died within twenty-four hours after the operation, not having recovered from its immediate effects. A letter was read from the physician who made the autopsy, describing the condition of the air-passages. The mucous membrane had the appearance of a recent application of the caustic.

Conclusions.—1. Catheterism of the air-passages dates its history from the time of Hippocrates.

2. The best evidences of the successful passage of an instrument into the air-passages, are the rational signs.

3. The facility of the operation depends upon the kind of instrument used—the tube having a large curve being best, and the sponge-probang least adapted to enter the trachea.

4. That there is no reliable evidence, in the opinion of the committee, that the sponge-probang has been passed through and beyond the vocal chords.

5. That there is no sure evidence that an instrument can be passed *at will* into the right or left bronchial divisions.

6. That in the great majority of instances where injections are supposed to have been thrown into the lungs through a tube, they have passed directly into the stomach.

7. That as regards the utility of injections of nitrate of silver into the lungs, the facts thus far developed in the experiment of the committee, lead them to regard the operation as one fraught with danger as well as difficult.

This report was signed by Prof. Parker, Chairman, Drs. Wood, Metcalf, and Stone; Dr. Anderson subscribed to all but that bearing upon the utility of injections; this he did not think sufficiently investigated; Dr. Stevens, who witnessed but a few experiments, made a short report. Prof. Barker made a lengthy minority report.

Report on the Progress of Materia Medica and Therapeutics. By EDWARD BALLARD, M.D.

[We make the following therapeutical extracts from Dr. Ballard's report on the progress of materia medica in the last number of the *Association Journal*]:—

FORMULA FOR COMPOUND IRON PILLS.

M. Bretonneau advises the following formula as one which obviates the constipating operation of the chalybeate when used for the cure of chlorotic affections.

Take of iron reduced by hydrogen, 16 *grammes* (ʒiv.)
Sulphate of quinine, 1 *gramme* (gr. xv.)
Powdered ginger, 1 *gramme* (gr. xv.)
Extract of yellow bark, 3 *grammes* (gr. xlv.)
Compound extract of rhubarb, 3 *grammes* (gr. xlv.)
Powdered Socotrine aloes, 5 *centigrammes* (gr. ¾.)
Syrup of saffron, q. s.

To form one hundred pills, which should be preserved in well-closed bottles. The dose is one pill in the morning fasting, and one at bed-time, increasing the dose, after a few days, to two pills night and morning. They may prove laxative. —*Bull. Gén. de Thérap.*

PHYSIOLOGICAL OPERATION OF STRYCHNIA.

The following conclusions are drawn by Paolo Montegazza (*Schmits Jahrbucher*, bd. 86, No. 5), from his experiments:—1. The only part which the circulation plays is to carry the poison mechanically to the nervous centres. 2. The gastro-intestinal tube, and the viscera in the hypochondria, do not exercise any essential influence in the production of the tetanus. 3. The nerves separated from their centre are unaffected by the poison, whether the latter be pure or mixed with blood. 4. The brain is not essentially necessary to the production of the tetanus. 5. The spinal cord, under the influence of the strychnia, is the only essential cause of the poisoning, and produces the tetanus by transmitting morbid currents to the nerves; the nerves are only the conductors of the diseased innervation, and the presence of the poison in them is not necessary to the production of the tetanus. W. Kaupp (*Vierordts Archiv. für Phys. Heilk.* 1855) has been making some experiments on the influence of loss of blood upon the operation of this poison, which tend to show that the symptoms of poisoning by strychnia, and the period of death, are both delayed by loss of blood. This fact is interesting, because opposed to the doctrine founded upon the well known experiments of Magendie, that the rapidity of absorption, and thus of the operation of poisons and medicinal agents, was increased by loss of blood.

FERROCYANIDE OF POTASSIUM AND UREA.

M. Baud (*L'Union Médicale*, May, 1855) proposes this compound as a substitute for quinine in the treatment of periodical diseases. He regards it as applicable to those fevers, neuralgia, spasmodic diseases and neuroses in which the intermittence is idiopathic, and not the result of marsh malaria. Its bitterness requires that it should be given in pills. M. Baud has usually given daily, in divided doses, ten to fifteen pills of fifteen *centigrammes* (about gr. ijss.)

FORMULA FOR ADMINISTERING PHOSPHATE OF LIME.

The insolubility of phosphate of lime has been an obstacle to its use. M. Kuchenmeister removes this difficulty by uniting the phosphate with carbonate of lime, and then adding an acid, when a soluble combination results. The proportions he uses are, carbonate of lime, 8 *grammes* (ʒij.); phosphate of lime, 4 *grammes* (ʒi.), sugar of milk, 12 *grammes*, ʒiij); sometimes he adds 1 or 2 *grammes* (gr. gv. or ʒss.) of lactate of iron. Of the powder, three pinches are to be taken at the commencement of a meal. The object of the addition of the carbonate of lime is to favour the solution of the phosphate. Under the influence of the lactic acid, or of the phosphoric acid present in the alimentary canal, carbonic acid is disengaged, and renders part of the carbonate soluble. The sugar of milk is intended to furnish lactic acid. The author remarks that the presence of albuminates is necessary to determine the solution of the phosphate of lime,—a condition which is present when the powder is taken with the food. (*Bull. Gén. de Thérap.*, June 1855.)

UVA URSI: AN ECBOLIC.

Mr. Harris has found a strong decoction of uva ursi, in cases where ergot would ordinarily be employed, to produce vigiorous pains, which soon caused the expulsion of both fœtus and placenta. The contractions induced are said to be less violent than those from ergot. (*Edin. Monthly Journal*, April, 1855, from *Virginia Medical Journal*.)

Notice of a Tonic Contraction occurring epidemically in Subjects affected with Typhoid Fever. By Dr. F. A. Aran, Physician to the Hospital St. Antoine, &c. (*L'Union Médicale*, July 19th, 1855.)

In the recent epidemic of typhoid fever, Dr. Aran has met with twelve cases in his service since last January, in which, at an advanced stage of the disease, when convalescence was beginning, the contractions showed themselves. With the exception of a single case, in which the appearances of the contraction coincided with the commencement of the disease, the contractions occurred after the sixteenth day of the fever. In none of the patients did the course of the fever appear in any way influenced by the new symptom, whether the former progressed favourably or otherwise. The attacks were sometimes preceded by formication, pricking, numbness of the extremities, and pain in the chief joints. The immediate seizure was announced by feelings of great anxiety and distress—it occurred at all times of the day. The contractions affected the upper and lower extremities, and especially the former; the two corresponding extremities were generally seized at once, though the arms presented occasional exceptions from this rule, by being attacked singly. The flexor muscles, which were the seat of the affection, exhibited almost incessant fabrillar contractions. When the entire upper extremity was attacked, the fore-arm was bent upon the upper arm, and lay upon the thorax, while the fingers were doubled up on the palm of the hand; the patient was unable to extend the limb, but by gradual manipulation an artificial extension could be obtained, and this gave the patient relief, though the parts resumed their morbid position when left to themselves. When the lower extremities were attacked, the contractions were less general, the leg was extended, the calves hard and painful, and the toes flexed and bent back. In four cases the muscles of the trunk were affected, producing opisthotonos, during which the patient was unable to execute any movement.

During the seizures, the contracted muscles were the seat of intense pain. The attacks lasted from a quarter of an hour to two or three hours, and recurred from two to ten times daily for several days, more or less. After the cessation of the attacks, the disease ran its ordinary course, without any residuary affection, beyond an occasional numbness of the affected parts. Three of the patients died, but this result was attributable to the severity of the fever, and not to the tetanic affection.

Dr. Aran is at a loss to account for the phenomenon which, according to the inquiries he instituted, appears to have been peculiar to his patients. He was inclined at first to set it down to the mercurial treatment which he habitually employs, but this conclusion is negatived by the fact, that of the twelve patients affected, five took no mercury. The employment of baths was regarded as having benefited the patients, and in one severe case of opisthotonos, chloroform inhalations gave relief.—*Med. Chir. Rev.*

DUBLIN: PUBLISHED BY W. B. KELLY,
8, GRAFTON-STREET.
LONDON: S. HIGHLEY, 32, FLEET-STREET.
EDINBURGH: MACLACHLAN & STEWART.
October 15, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.
SENT FREE BY POST.
Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 19.—Vol. II. NOVEMBER 1, 1855. Price 5d.

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PHYSICIAN TO THE MEATH HOSPITAL, LECTURER ON PRACTICE OF MEDICINE.

No. II.—*Acute Gastritis, Sympathetic Affections, Causes, Diagnosis, Treatment.*

Sometimes, however, none of the usual symptoms of gastritis are present, and if we have not seen the patient at an early period of the attack, or received an accurate history of the case, we may be deceived; as the sympathetic affections of the gastric mucous membrane are generally severe and numerous, simulating disease of the nervous, respiratory, or circulatory systems, according to the habit and degree of susceptibility of the patient, the irritation being at one time reflected on the brain, and we have then a predominance of nervous symptoms indicated by intense headache, restlessness, intolerance of light, delirium, convulsions, and coma; in fact, symptoms indicative of inflammation of this organ, and yet no alteration be detected in the nervous centres after death. A remarkable case of this kind occurred in the Meath Hospital under the care of Dr. Stokes. A man was admitted labouring under violent maniacal excitement; the eyes bloodshot, and his aspect ferocious; he had thirst, a dry and shrivelled tongue, but the belly did not seem tender; the pulse was quick and weak; the cerebral symptoms increased, and he died on the eighth day. Dissection revealed intense inflammation of the stomach and digestive tube, but none in the brain or its membranes.

Andral has recorded two cases, which are remarkable examples of the predominance of nervous symptoms in gastritis; in one case the usual symptoms were suspended by the supervention of tetanus; in the other, the symptoms were those of violent inflammation of the brain, and yet, on dissection, no morbid appearances could be discovered in the brain or spinal cord, but the inner coat of the stomach was intensely inflamed in both cases; and they afford good illustrations of a pathological law which we ought always to bear in mind when treating diseases of the digestive system, namely: "*that when the sympathetic symptoms acquire a certain degree of intensity, the more usual, or what may be termed the local symptoms, are either greatly lessened, or altogether wanting.*

Illustrations of this law occur in the practice of every physician, particularly in the case of children's disorders, where we often meet with this apparent transition of disease, inflammatory affections of the stomach and intestines simulating cerebral disease, and the headache, delirium, even convulsions subsiding on the application of leeches to the epigastrium. The heart may also be affected from sympathetic irritation in the stomach, evidenced in some cases by increased impulse, in others by occasional intermissions of its pulsations, by irregular action, or violent fits of palpitation; but the organs of respiration suffer more from this sympathetic irritation than any other system, as their intimate nervous connexion by the branches of the par vagum, and their anatomical relations, might lead us to suppose; in fact, hurried breathing, with or without cough, is a very constant symptom in inflammatory conditions of the stomach, in children particularly, and it is in these cases that the great advantage of the stethoscope is manifest, for without its aid we should often find great difficulty in making up our mind as to the exact seat of the disease.

A good example of this difficulty occurred in the case of a man admitted under my care to the Meath Hospital, complaining of tightness across the chest, great difficulty of breathing, severe harassing cough, and expectoration tinged with blood. His chest was examined carefully by Dr. Stokes and myself, but we could not detect any disease in his lungs; we also learned that his illness had commenced with sickness of stomach and vomiting, after committing an excess in drinking, and therefore concluded that it was a case of sympathetic irritation of the lung depending on gastritis, and all the pulmonary symptoms rapidly subsided under treatment directed to the stomach. Dr. Stokes has laid down some valuable rules to guide us in our diagnosis of these cases: first, the want of proportion between the apparent symptoms and the physical signs derived from auscultation; and secondly, the length of time the symptoms have lasted; for, if symptoms of violent pulmonary disease are present, and yet no physical signs of inflammation can be detected by percussion or the stethoscope, after some days, we may feel certain that the symptoms are caused by some sympathetic irritation.

Causes.—Acute gastritis is rarely produced by the common causes which excite inflammation in other parts of the system, as cold, damp, fatigue; its causes may be said to be such as act, not so much through the general system, as by a direct operation on the stomach itself. It most frequently results from caustic or irritant substances taken into the stomach. Large quantities of cold water, ice, cider, sour beer, taken after fatiguing exertion, when a person is heated and *exhausted*, are highly dangerous; excess in eating or drinking, particularly if the person be convalescing from an acute disease, is very apt to induce it. We meet with it also in some cases of delirium tremens by excess, and it may then be the cause of a sudden fatal termination, as occurred in a case of a young gentleman whom I lately attended, who was attacked with delirium tremens after a debauch. I saw him on the fourth day of his illness, when he complained of intense thirst for cold drinks, but which he vomited instantly; he was in a state of collapse, no medicine would stay on his stomach, nor could we even vesicate the epigastrium, and he died suddenly (when sitting up to take a drink), in a few hours after my first seeing him.

Inflammation of the mucous membrane of the stomach may be caused by other conditions besides those I have enumerated; thus severe or long continued abstinence will be followed by changes in this membrane which much resemble those caused by inflammation; this state has been particularly noticed by M. Andral, who says: "In some experiments which I undertook with M. Gavarret, for the purpose of determining the composition of the blood in animals deprived of food, one circumstance particularly struck me, namely, a notable augmentation in the proportion of the fibrin. My astonishment ceased, when on opening the bodies of these animals, I found in their stomachs evident signs of inflammation, such as bright redness, softening, and numerous ulcerations of the mucous membrane."

These facts should be constantly borne in mind by all practitioners, when treating cases of *continued* fever, particularly in this country, as there is no doubt but that abstinence or *low diet*, too long persisted in, has often been productive of very bad consequences in such cases, and hence you see that we allow our patients in fever to have bread and milk, or tea, from the very first, and nutritious broths at a very early period; in fact, as forcibly expressed, by my talented predecessor, the late Dr. Graves, we "feed our fevers."

Inflammation of the mucous membrane of the stomach may also be excited by the introduction of a noxious poison at a remote part, as occurred in the experiments performed by Mr. Hunter, Home, and Sir B. Brodie, who states that "the inflammation is greater in degree, and more speedy in taking place when arsenic is applied to a wound, than when it is taken into the stomach. The inflamed parts are in general universally red, at other times they are red only in spots. The principal vessels leading to the stomach and intestines are turgid with blood; but the inflammation is usually confined to the mucous membrane of these viscera, which assumes a florid red colour, becomes soft and pulpy, and is separable without much difficulty from the cellular coat, which has its natural appearance;"* that he has never found ulceration or sloughing of the stomach or intestines in any of his experiments, but thinks it may terminate in these ways, if the animal survived a certain time; and though the inflammation from arsenic, occupying in general the whole of the stomach and intestines, is more extensive than that from any other poison with which he was acquainted, yet it does not affect the larynx or œsophagus, and this circumstance distinguishes it from the inflammation which is occasioned by the actual contact of irritating applications. In nearly similar cases which have occurred in the human subject, violent pain in the belly, vomiting, and diarrhœa have been the chief symptoms; and after death marks of extensive inflammation of the mucous membrane of the stomach and intestines are found. We have also evidence of the noxious influence of a morbid poison acting on the stomach through the blood, in the case of yellow fever, in which we find great congestion of the stomach; and we may also include, under the same head, many of the cases of sudden retrocession of gout, when violent pain in the stomach, with constant vomiting and high fever, occurs during an acute attack of this affection in the joints, and which we may consider as gouty inflammation of the stomach, requiring a very different line of treatment from the more frequent form of spasm or cramp in the stomach, which is not inflammatory, not attended with vomiting or fever, and is best treated by stimulants.

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* Philosophical Transactions, 1812.

Diagnosis.—The diseases most likely to be mistaken for gastritis are *peritonitis* and *hepatitis*, as they are both inflammatory diseases, attended with severe pain and tenderness in the epigastric region, vomiting, thirst, and the other symptoms of gastritis; but our diagnosis should be derived first from the situation of the pain, which in peritonitis is diffused generally over the abdomen, while in hepatitis it is confined to the hepatic region, and generally accompanied with physical signs of enlargement of the liver; the peculiar character of the thirst and history of the case will also serve as guides to the diagnosis. Gastrodynia, nervous vomiting, hepatic and nephritic colic have each in their turn been mistaken for it, but the absence of fever, as well as the other symptoms peculiar to each case, should prevent your making such errors. The severe gastric symptoms which occasionally usher in an attack of acute hydrocephalus and other diseases of the brain, might deceive you, but they are seldom attended with the intense thirst and epigastric tenderness which characterise gastritis. The extreme irritability of the stomach which often precedes the eruption of scarlatina or variola might also mislead you, if you were not on your guard, as you often have intense thirst, vomiting, pain in the stomach, as premonitory symptoms in both these diseases, so never be in a hurry to make a positive diagnosis in such cases, for though at first the exact diagnosis may be difficult, yet you will generally find that other symptoms will soon develope themselves, and enable you to come to a right conclusion.

The indications of treatment in acute gastritis are, 1st, to remove the exciting cause; 2nd, to relieve the inflammation as quickly as possible; 3rd, to avoid everything that can excite the stomach; 4th, to moderate the sympathetic affections. If poison has been taken, you must try to remove it, and neutralize its effects; but if the case be idiopathic, and you see it at an early period, you should commence the treatment by bleeding from the arm, watching its effects carefully; for, though the type of the fever is at first inflammatory, yet it rapidly assumes a typhoid character, and is then apt to deceive the physician, who, merely regarding symptoms, only sees debility in the prostration, and plies his patient with stimulants, which aggravate the debility by increasing its cause; so, if the pulse increases in strength while the blood is flowing, you may persist till fainting is induced; but the chief remedy consists in the application of leeches to the epigastrium, and more advantage is derived from applying them in relays, than in abstracting much blood at once, and you will often find all the symptoms subside during their application. Apply a light poultice after the leeches fall off, and keep the patient perfectly quiet in a horizontal position, for this disease exercises a very depressing influence on the action of the heart, and fatal syncope may be easily induced. Let him have very small quantities of *cold* drink at short intervals; iced water, or a lump of ice left in the mouth till the edges are smoothed, and then swallowed, is very grateful. Be cautious of effervescing draughts, as they often aggravate the pain by distending the stomach with gas. Give one grain of calomel every second hour till the mouth is affected, and, if the vomiting and pain are severe, follow each powder with one or two drops of hydrocyanic acid in cold water; blister the epigastrium, and dress the blistered surface with a quarter or half a grain of acetate of morphia in powder or mixed with lard. Do not give any purgative by the mouth, as it would be rejected, and only increase the inflammation; but use enemata, either purgative or of warm water or gruel; if there is any irritation in the bowels, you will often find opiate injections of use; twenty-five or thirty drops of laudanum in three or four ounces of starch will allay tenesmus, and also often help to tranquillise the stomach. Be very cautious of allowing any solid food or stimulant, as a relapse is easily induced, and generally proves fatal, indicated by the tongue becoming covered with apthæ, the pulse quicker and smaller, great emaciation, restlessness, and debility, vomiting, or rather regurgitation of everything swallowed, and of a dark substance like coffee-grounds, but which is blood, modified by the chemical action of the gastric fluids, the countenance gets greatly sunken and the abdomen swelled; finally, all pain ceases, except in the case where perforation of the stomach has taken place from the action of some corrosive poison.

Dr. Wood, of Philadelphia, states that he has seen one apparently desperate case (where the symptoms indicated gangrene) recover under the use of oil of turpentine, given in small doses, in combination with laudanum.

On a Mode of Testing the Translucency of Hydroceles by the Stethoscope.

BY DR. W. FRAZER,

LICENTIATE OF THE KING AND QUEEN'S COLLEGE OF PHYSICIANS, ETC.

I am anxious to direct attention to what I believe to be one of the best methods of employing the valuable test of translucency in hydrocele, a test which is practically so important as a differential diagnostic in discriminating between mere serous effusions in the cavity of the tunica vaginalis and various affections of the testicle, or scrotal hernias. Of course, every one is aware that the test is not free from objection; thus, it is almost or entirely useless in those instances in which the effused fluid is of very dark colour, or is mixed with blood, &c., and also whenever the tissues of the tunica vaginalis are of unusual thickness, or are the seat of cartilaginous or osseous deposit, or when they are coated internally by the products of previous inflammatory action. Independent of these exceptional cases, there are a number to be met with in practice, in which the test is of value.

As ordinarily employed, by placing a candle at one side of the tumour, and excluding the passage of the light laterally by means of the hand, it is, at best, a clumsy proceeding, and liable to errors. I have found the stethoscope much more useful, as a means of excluding the diffused light, and by applying the eye to its expanded bell-shaped portion—the ear-piece being firmly placed upon the scrotum, held in a tense condition—we can even map out the state of the parts with tolerable accuracy, if the contained fluid be of ordinary character, and detect the position of the testicle by the opacity it produces, especially when it occupies any unusual locality, as the front or sides of the scrotum, or is adherent from inflammation after previous tappings. We can employ either a lighted candle or bright sun-light, as our best means of obtaining the requisite illumination; but even in diffused day-light, I have succeeded very well in the manner I mention.

On The Treatment of Cholera.

BY DAVID JAMISON, M.D., Newtownards.

The best means of treating Asiatic cholera being still undetermined, perhaps the following brief and bare summary of the treatment of a few cases may have a small value, as an addition to the data from which to learn the best remedies.

I treated 106 cases of Asiatic cholera in the Newtownards Union Hospitals: fifty-one of these cases had profound *collapse*—were blue, cold, prostrated, and, save a very few who had a vestige of pulse, were pulseless—either at the time of admission or soon after. I had twenty-eight deaths in all: twenty-four of these occurred in collapse, and four in the stage of reaction; two of these were children, and died with symptoms resembling hydrocephalus (a state from which two or three children recovered). The success of the treatment seems above average, and cannot altogether be accounted for by the fact, that a few cases were admitted after reaction was established, and a few others had received a dose or two of medicine from the gentlemen employed by the Dispensary Committee to treat patients at their own homes. The cases alluded to, admitted in consecutive fever, did not exceed five or six. All the cases but two were sent in from the Union, the other two were cholera nurses.

I may premise that the majority of the cases were treated in the cholera hospital, a wooden building, erected in 1849; it is commodious and comfortable; the remainder were treated in a large ward of the fever hospital. I had an unlimited supply of blankets and bed-clothes, and everything I wanted was supplied at once by the directions of the Board of Guardians.

External Treatment.—On admission the patients were put to bed and surrounded with warm blankets. If in collapse, either the hot wet sheets, as recommended by Mr. Barwell, were used, or sinapisms, hot oil of turpentine over the whole body, applied by hand-rubbing on flannel, bottles and tin vessels of hot water, hot bricks, &c., were used. The hot wet sheets, and the hot turpentine, were found the best means of warming and reviving patients. Hand-rubbing towards the heart, with or without turpentine, was used on the legs and arms of almost all cases. In many cases I put a large fly-blister over the abdomen; when it acted it always did good. Cases admitted with vomiting, purging, and cramps, but not collapsed, had warm heavy bed-clothes put on, and the abdomen covered with a mustard poultice, &c. Often in the early stage, and always in convalescence, I applied mustard over the kidneys, and frequently it seemed to promote the secretion of urine. Leeches were occasionally used in the congestive affection of the brain, but blisters to the nape of the neck were found more useful. Friction, ligatures, and warmth were used for cramps. The quantity of bed-clothes was diminished when patients rallied and got warm: perspiration was never solicited, indeed free perspiration occurred in only two cases; in one it accelerated death, in the other—a strong man—it cured the disease. The hot wet sheets never produced any amount of perspiration.

Internal Remedies.—Gallic acid, in five grain doses, was the staple remedy; it was used in almost every case, always with one grain or half a grain of calomel, and occasionally with camphor, ginger, and opium, given in sugar and water, after each discharge from the bowels, if these were marked, or with frequency proportioned to the occasion. I had used acetate of lead, acetate of quinine, and acetate of morphine, dissolved in vinegar and water, in some cases, at the first, but ceased to use it: perhaps before testing its value sufficiently I distrusted it. For vomiting and burning pain in the stomach, the remedy most used was five grains each of subnitrate of bismuth and carbonate of soda, with a little sugar. Aromatic spirit of ammonia and laudanum, also sulphuric æther and laudanum, were used in severe vomiting. Calomel in large doses was tried in some cases of collapse; I ceased to have faith in it. I never gave opium freely, and only occasionally, in small doses, with the gallic acid or bismuth. In a few cases starch enemata with laudanum were used. Whiskey punch was given in many of the first cases: I came to think it seldom did good, and sometimes did harm—in fact that nurses and patients were better without it; where I thought stimulants might do good, I substituted with advantage aromatic spirit of ammonia, or sulphuric æther, or essence of peppermint, or strong tea. My patients were permitted to drink only a small quantity at once. Tea, new milk, broth, &c., were given to all.

In the consecutive fever the organs inflamed or embarrassed were blistered, the bowels were opened with rhubarb and calomel; spirits of nitric æther, antimonial powder, acetate of potass, and cream of tartar were given; the body was sponged over with warm water, frequently patients were well washed with soap and water, and mustard or turpentine, as I stated before, was applied over the kidneys. A feverish state, more or less protracted, occurred in *every* case that recovered. In no case did salivation occur. My patients were, on the average, fifteen days under treatment.

It is foreign to my present object to say anything of local conditions or circumstances, which may have promoted the outbreak of cholera here, or caused its spread and delay.

Perhaps it is worth while to state, that I treated a great many cases of diarrhœa before and during the prevalence of cholera; and found, in mild cases, one part of laudanum and two parts of tincture of ginger, in doses of sixty drops in sugar and water three to six times daily, with a mustard poultice to the abdomen, and a warm foot-bath, frequently to effect a cure. In severe cases, Donovan's lead mixture, or opium pills of two grains, given freely, with whiskey punch occasionally, formed good remedies, when patients were kept warm in bed for a day or two, and had mustard, turpentine, or flies applied to the abdomen. I think sulphuric acid may be a good preventive remedy; but I firmly believe we have other far better means of treating diarrhœa, dysentery, and cholera. I tried it in diarrhœa and dysentery, with unsatisfactory results. I deem it a fact of some interest, that not a miner at the Newtownards lead mines, where about five hundred hands were employed, had cholera, though many of the men lived in cholera districts of the town, and some of them had cholera in their families; at least I do not know of one case having occurred among them, and certainly not a death occurred. These men wear strong coarse flannel next the skin night and day. Could this have protected them? Diarrhœa prevailed among them during the cholera epidemic; it was seldom so severe as to prevent them working.

I have been as brief as possible, as I know your journal could readily be occupied with more valuable matter, and that I can say nothing new of cholera. If there be anything uncommon in the treatment I pursued, I suppose it is the free use of gallic acid. How much of the success was owing to it I will not affirm; but my belief is, that it restrained the purging often when no other known astringent would. Should I have cholera to treat again, I would be less afraid to use laudanum or opium; I would use whiskey and stimulants less; I would give *no* calomel in collapse or purging; I would use the same external means as before; gallic acid I would use, and the lead and quinine mixture I would, perhaps, give a fair trial to; fluid aliment, as Liebeg's juice of beef and concentrated soups, &c., I would also give.

CASE OF RUPTURE OF THE SPLEEN, FROM EXTERNAL VIOLENCE, FOLLOWED BY PLEURO-PNEUMONIA; FATAL.

BY DR. DUFFIN,

ASSISTANT SURGEON TO THE 46TH REGIMENT, CRIMEA.

Thomas Powell, æt. 21, a soldier of the 57th regiment, was admitted into hospital on the 8th of September. The day of the final attack upon the Redan he was in the trenches, and was hit on the left side by a piece of shell. I saw him at the time, and ordered him to be taken to our field-hospital in camp. He walked the whole of the way; when on his arrival he was further examined by Dr. Macandrew, the surgeon of the regiment. At the time he was suffering from severe pain in the left side, which was augmented by pressure over a circumscribed space, corresponding to a point a little external to the cartilage of the ninth rib, and not more than three inches in circumference: anxiety of countenance and accelerated pulse, but no abrasion of the surface—no fractured rib—no swelling, or discoloration of the part. He was treated for the symptoms, and discharged two days after, viz. on the 10th, at his own request, and, to all appearance, quite well. He returned to his duty, which he performed as usual, until the 12th, when he was readmitted under my care, labouring under the following symptoms:—general increased heat of the surface of the body; pain, of a violent character, in the small space already referred to with very intense heat, hard and quick pulse; tongue covered with a whitish fur. The stethoscope revealed a slight crepitus at the base of left lung; rather difficult breathing; and very deep inspiration, evidently causing pain; the epigastric region was distended, and the whole abdomen tympanitic. Percussion gave a clear and normal sound over both lungs.

Treatment.—He was bled from the arm till syncope was produced; subsequently twenty leeches were applied to the painful part; calomel, antimony, and squills were given; salivation was produced rapidly, and the action of the mercury kept up until the 25th. This was the chief treatment. He died on the evening of the 26th, in an agonising state. For several days he seemed to be improving, and could talk with ease and freedom from pain; but on the 20th the crepitus in the left side, at first very indistinct, became quite audible, and extended over the greater part of the same side, even over the pericardium. Pressure at no time gave pain except in the one small spot.

Post Mortem Examination.—The pleuræ of the left side were throughout their whole extent highly vascular, particularly the costal, and in the lower part of the side numerous small specks of lymph were plainly visible to the eye; there was no decided thickening except at those points. The pleuræ were united by a few soft shreds of lymph: a small patch of the base of left lung was congested, in other respects both lungs were healthy, though much contracted in size. The pleura costalis and pulmonalis of the right side were united by numerous bands of recently effused lymph, but no other trace of inflammation was present. The cellular tissue of the anterior mediastinum was congested; the pericardium contained a large quantity of serum, but in it there was no vascularity; the small capillary vessels, on the surface of the heart, were plainly seen, and presented a beautiful network appearance. The peritoneum throughout its entire extent was of an almost perfectly black appearance, as well that of the parietes as of the intestines; the omentum was, likewise, black, but in no other respect did the peritoneum differ from its healthy character. It was still glistening, tense, and elastic. The stomach and intestines were greatly distended with gas. The spleen was of about three times its ordinary size, ruptured to the extent of two inches in its long axis, and to a considerable depth in its anterior and external aspect; its substance was infiltrated with congealed and black blood; the vessels entering and leaving were uninjured. There was no fractured rib, no laceration of the parietal peritoneum. The liver was healthy, nothing abnormal apparent about it.

Hospital Reports.

RICHMOND SURGICAL HOSPITAL.

Labial Cancer in the Female.

Two additional cases of cancer of the lower lip presented themselves under Dr. Fleming, in women aged about 50, 54; each a widow, and each a mother of children, neither having been smokers.

In each this disease was seated in the left half of the lip, having commenced with a crack or fissure in the red portion. The growth was slow and progressive during the space of two years, and now presented the usual appearances of ulcerated cancer, involving the mucous and cutaneous surfaces. In one, the ordinary operation of angular excision was performed, and the hypertrophied condition of the mucous glands was remarkable, especially on the divided surfaces, whence they were easily snipped off. The two lower needles were removed after the lapse of twenty-four hours, and yet the tract of each needle suppurated, and was as slow in healing as those of the third needle, although it was not removed for forty-eight hours.

In the second case no operation was performed, the cancerous mass of the lip being consolidated to the side of the jaw, the submental glands being enlarged, remarkably hard and dense on pressure, and the integuments identified with them, and highly inflamed. In the latter case, different local applications had been made, and no surgical assistance was sought for until the present application. The general aspect of this woman did not manifest any malignant taint. Her condition was good, and her suffering was more mental than otherwise.

The occurrence of three cases of labial cancer in the female, within the limited period of six or eight weeks, in the same hospital, is rather remarkable.

Vesical Calculus.

Mr. Fleming has two cases of vesical calculus under treatment at present, and contemplates the cure of each by lithotrity. The subject of one case is a man aged about 54-5. He is a carpenter by trade, and has been labouring under equivocal symptoms of the disease for about two years. He had been treated for prostatic enlargement, accompanied with chronic cystitis, and the ordinary characters of the latter disease were well marked. On examination, however, Mr. Fleming detected the presence of a calculus, which, on measurement, he found to be about an inch or so, in any diameter in which he was enabled to catch it. From the peculiar dull sound communicated to the instruments used, as well as from the prominent features of the urine, he came to the conclusion that the calculus was, externally at all events, phosphatic. In the examination made, the man evinced much placidity of temper, and much tolerance of the requisite manipulations. The bladder also was capable of retaining (except during a paroxysmal attack) from four to six ounces of urine, and the calculus was caught without any difficulty. The operation of lithotrity having been selected, it was decided that chloroform should not be used. The first sitting took place on Wednesday, the 17th ult., the usual appliances were used, yet much annoyance was experienced from the intolerant restlessness of the patient. Throughout he was not very amenable. The screw lithotrite was that used. In its working movements no apreciable sound was communicated, and yet on its removal the slot and teeth were coated with detritus; a good deal of the latter also escaped through the catheter. A second sitting took place on the third day, and there was another after the lapse of the same period, and, although under chloroform, far from being satisfactory. After the first operation the urine was coloured with blood, and the mucus was also tinged. Detritus has escaped in considerable quantity, and as favourable progress proceeds as can be expected at this stage.

The second case was one of much interest. The subject of it, a child aged three years, who for six months back has been labouring, at irregular intervals, under severe urinary paroxysms, with all the associated rational signs of stone. Mr. Fleming is fully under the impression that a stone exists in the bladder, and that the stone is very small, so small that it can only be felt as if by accident, and at the time at which staff, sound, or catheter is being withdrawn from the bladder. He has, on other occasions, not been able to feel any calculus, in the empty or full state of the bladder. Those of his colleagues who sounded the child were not satisfied of its presence. The child was sent home, somewhat relieved from the more painful symptoms, but yet uncertain as to their very serious recurrence, in shape of complete or partial retention of urine, or of incontinence of urine, and the most agonizing forcing efforts occasionally to discharge it. Instruments, ranging about No. 6 on the ordinary catheter scale, entered the bladder with ease. Mr. Fleming was anxious to catch and break the stone, as he understood was not unfrequently done by Mons. Guersent of Paris, at the *Hôpital des Enfans Malades*. Through the kindness of his friend Dr. Higgins, of Paris, he procured the most improved *Brise-Pierre* of M. Charriere, and tested by M. Charriere as a safe lithotrite. The principle of this instrument appears to be that of Civiale's on a small scale. Mr. Fleming introduced the instrument with ease, and found its several movements most manageable and most satisfactory. He has as yet failed, however, in catching the stone, though he feels satisfied that he struck it more than once. His impression is that the stone is thrown into the neck of the bladder by the expulsive efforts of the latter. Three several examinations were made while the child was under the influence of chloroform, and they were not productive of any additional suffering to the little patient. The anæsthetic effects of this valuable agent passed into a sleep, from which the child awoke unconscious of suffering, and alive to his ordinary amusement.

Mr. Fleming purposes renewing the attempt at lithotrity in this case, and hopes either to succeed in breaking the stone, or facilitating its exit through the urethra by the attending dilatation of the latter tract.

SKIN DISEASES.

From the French of M. Maurice Chausit.

BY JOHN K. BARTON, A.B., M.B., T.C.D., &c.

(*Continued from page* 281.)

ORDER II.—*Non-specific Eruptions which exist only in a Chronic Form.*

Lepra and Psoriasis.

Lepra and psoriasis constitute two remarkable varieties of the affections known as *scaly* (Squamæ, Ord. V. in Willan's Classification); that is to say, affections characterized by the production over the diseased surface of a substance dry, friable, and laminated, differing in thickness and the strength of its adhesion in different cases, and the formation of which is never accompanied by either serosity or perspiration. This elementary product, known under the name of Scales, differs essentially from the lamellæ, or epidermic debris, which we see after any accidental inflammation, such as erythema, or any of the vesicular eruptions; it is the result of a morbid, but incessant, secretion of the epidermis, depending upon a diseased condition of the whole skin, which causes the prompt and continued reproduction of new scales when the old ones fall off. Three distinct varieties exist of scaly affections:—1. lepra; 2. psoriasis; 3. pityriasis; each of these possess certain characters peculiar to themselves, while all come under the description just given of a scaly affection. Lepra and psoriasis present numerous points of analogy: they are developed under the influence of the same causes—their nature is identical—the same treatment is applicable to both. Yet, in spite of these points of resemblance, we cannot (says M. Chausit) agree with those who consider them merely as varieties of the same species, and describe them together, as they are perfectly distinct in their external characters. We, therefore, think with M. Cazenave, that while a separate description is demanded of their appearance and symptoms, their causes, nature, and treatment, are to be considered the same.

Lepra.

Definition.—Lepra is an inflammation of the skin, characterized by round or oval discs, projecting, the centre of which is healthy, and the circumference covered with scales of variable size and thickness, which fall and are re-produced incessantly.

Symptoms.—Lepra appears by little red points, slightly raised above the surrounding skin, which are incompletely covered by little scales thin and dry, easily rubbed off, and quickly reproduced. These points become flattened and widen, the centre remaining healthy and intact, while the scaly circumference becomes more distinctly marked. According as the disc becomes larger and more complete, the scales become thicker and more adherent; this increase in thickness is accompanied generally by a change in the colour of the scales, which become of a deep grey.

The sizo of the leprous spots are very variable. When the scales have fallen off, we see that the surfaces are irregularly furrowed. Lepra vulgaris appears ordinarily upon the limbs and round the articulations; its development is slow; it attacks progressively the abdomen, the shoulders, and the trunk; it but seldom engages the scalp, and still more rarely the face or hands. Sometimes the discs of lepra are scattered all over the limbs and trunk, and again they will be found close together and confluent. The extension of this complaint takes place without disturbance or derangement of the general health. Locally, the patient feels neither itching nor pain, except sometimes a feeling of tension, or when the patches are situated round the articulations, then movement becomes painful.

It may be laid down as a general rule, that in lepra, but especially in psoriasis, perspiration is scanty; even after active exercise it is limited to the axillæ, palms of the hands, or soles of the feet. If it be true that lepra and psoriasis are essentially diseases of the epidermis, it is difficult to explain this remarkable fact of the arrest of perspiration. It seems to suggest that they are, in truth, diseases affecting the whole constitution of the skin. Lepra sometimes remains stationary for a very long time; but it is not rare to see it diminish and disappear at a certain time of the year—spring-time or autumn—to re-appear again the following year. Again, we may have the circles of lepra continuing to enlarge, so as finally to become confounded with one another; the centres then often become covered with scales, and the disease differs in nothing from psoriasis. When recovering the centres clear first, then the circumferences. It is from such facts as these, that some authors have classed lepra and psoriasis together as mere varieties of the same disease; but this transformation of one scaly affection into another constantly occurs amongst them; and, as a general rule, lepra preserves its own peculiar physiognomy, viz. the circles with a healthy centre, without any modification until its termination.

Psoriasis.

Definitiion—Psoriasis is a chronic inflammation of the skin, characterized by projecting patches of irregular form and variable in size, covered with dry scales, of a brilliant white colour.

Psoriasis may appear over the whole surface of the body; rarely it is confined to a single district; occasionally, however, it is, and this has given rise to several local subdivisions of the disease, which demand no special description. The subdivisions founded upon the various appearances and nature of the eruption are well defined. They are the following:—1. P. guttata; 2. P. gyrata; 3. P. diffusa; 4. P. inveterata.

Psoriasis Guttata appears in the form of little isolated papulous points, covered completely by a thin shining scale, which appears to constitute the whole malady. These little spots are elevated in the centre; they enlarge a little, but never acquire any great size; they always remain distinct from each other; the brilliant scales which cover them give the appearance of drops of water scattered over the body. This form, which we may call the first degree of psoriasis, chiefly occupies the posterior part of the trunk, and external aspect of the limbs; it is developed chiefly during spring and autumn, and most frequently in adults and females. Psoriasis guttata is accompanied with a slight itching, chiefly in the evening and at night.

Psoriasis Gyrata.—This form, described both by Willan and Biett, may be considered as a psoriasis guttata, in which the spots, in place of being disseminated without order, are disposed so as to represent some regular form, such as a figure of eight, or a spiral curve. This variety is rare.

Psoriasis Diffusa is more serious; it shows itself chiefly on the limbs, where it appears first in the form of separate elevations, but which quickly become confounded together, forming irregular, extended patches, covered with scales. It generally commences around some of the articulations, such as the elbow or knee, thence spreading over the neighbouring surfaces. Thus, a single large patch is often seen occupying the whole anterior aspect of the leg, or posterior part of the fore-arm. The scales, thick and adherent, are detached with difficulty; when they fall, the surface which they covered looks red and furrowed; and if we examine it closely, fresh, thin, shining little scales will be seen, as it were, in process of formation. Psoriasis diffusa is a common form of the disease, very rebellious, principally attacking adults.

Psoriasis Inveterata is remarkable from the degree of intensity which it presents, which is not always, as might be supposed, in proportion to the duration of the disease. The scales become dryer by degrees; the skin which they cover becomes thickened, red, and rough; it cracks, and becomes the seat of a copious and unceasing desquamation. This exaggeration of the epidermic secretion is sometimes very remarkable, particularly when the disease has attacked the whole surface of the body: the exfoliation, as it were, rains from the patient; when he rises the sheets of his bed are covered with it; the skin seems transformed into a surface for secreting scales. Arrived at this degree, the disease presents a sufficiently formidable aspect; the movements of the limbs become painful from the fissures which surround the joints; and the patient's yielding to the feeling of itching renders them more painful still. The nails lose their transparency, become yellow and dirty-looking, then dry and broken, and finally drop off, and are replaced by an irregular and scaly mass. Psoriasis inveterata is always rebellious to treatment, as its name implies; and is generally induced by privations, habitual want of cleanliness, or, on the other hand, excess of all sorts.

Sometimes it is complicated with a general erysipelatous inflammation of the skin; the scales fall; the integument becomes red and painful, and a general disturbance of the system, more or less intense, takes place. This is always an accident, and not a normal phase of the disease; it generally disappears in a few days, without producing any amendment in the scaly disease. M. Cazenave, however, had one case of general psoriasis inveterata, in which this acute attack was followed by an immediate improvement which lasted several months; and very curiously, the scaly affection was finally replaced by an eczema of both legs.

Causes.—Lepra or psoriasis is never developed under the influence of any merely local cause. They are the effect of a peculiar constitutional state of the skin, which may be either hereditary or acquired; the circumstances which appear to cause their development are of but secondary importance. The scaly affections are to be met with at all ages, but chiefly between fifteen and twenty-five. They are not contagious; they are often hereditary; and have a marked tendency to relapse. We have seen lepra and psoriasis appear after certain diseases which profoundly affect the skin—variola, for example; but these are be considered as but secondary causes.

Seat and Nature.—The scaly affections form a kind of connecting link between the acute inflammatory diseases, on the one hand, most of which we have already reviewed, and the lesions of secretion on the other, which will next come under our notice. There exists certainly chronic inflammation, but its results are very different from those of the vesicular or pustular inflammations, in which serous or purulent fluid is poured out. Here we have an alteration of the epidermic secretion; no new product formed, but a normal secretion vitiated under the influence of the inflammation. Scaly diseases are to be considered not so much local diseases as the result or expression of a state of system, which we cannot, in the present state of our knowledge, define, but which we know to be often hereditary.

Treatment.—From what has been said of the causes and nature of the scaly affections, together with the fact of their tendency to relapse, we are prepared for the announcement that a great number of different kinds and plans of treatment have been practised for their cure, and frequently with very indifferent success. Often the cure which seems to have been obtained lasts but for a few weeks or months, when the disease returns more obstinate than ever. The difficulty and uncertainty of obtaining a radical cure has made some maintain that lepra and psoriasis are incurable; and that, in consequence, none but palliative and local treatment ought ever to be adopted, particularly as the internal treatment generally recommended consists in the administration of drugs which may greatly injure the constitution. But although internal treatment will not ensure the patient against a relapse, yet it is the only means by which a lasting cure can be obtained; and even to obtain a temporary improvement, all clinical experience proves that internal treatment is preferable to any other. Whilst maintaining that local treatment is not to be relied upon for the cure of these diseases, we think it may often be employed with great advantage in addition to the more slowly acting constitutional treatment.

The two following ointments often produce the most marked and rapid improvement in scaly affections: 1st, an ointment of the iodide of sulphur, introduced by Biett, in the proportion of ℈ii. to ℥i. of lard; 2nd, a pitch ointment used on a large scale by Mr. Emery, in the proportion of ʒi., ʒii., or ʒiii. to ℥i. of lard. Various kinds of baths have been used and advocated; the only one we have found of any use are vapour baths, at 28° to 32° R. When the disease is light, just at its commencement, or occurring in the young and delicate, we have found the administration of sulphur internally, with the use of sulphur bath, very useful. Amongst the agents used internally, and highly praised, are the tincture of cantharides, and the subcarbonate of ammonia; the first of them was given with success by Biett, in the dose of 25 to 30 drops a day, beginning with 3 to 5 drops at first, and gradually augmenting for seven or eight days. The subcarbonate of ammonia has been used by M. Cazenave, who recites examples in which, by means of this agent, he has obtained a cure after the arsenical preparations had failed. It may be taken in doses of from 5 to 15 grains without inconvenience. The preparations of arsenic have, however, an incontestable superiority over all other modes of internal treatment. In spite of the objections that may be alleged against their use, the marked success which follows their administration must place them first in the list of means we possess to combat the scaly affections. The action of arsenic appears to be direct upon the skin, the functions of which become reanimated under its influence. When given with caution no evil effects can follow its use; but if nausea, colicky pains, or diarrhœa supervene, the treatment must at once be suspended.

The preparations best fitted for use are the solutions of Pearson and of Fowler, and the Asiatic pills. Pearson's solution is the least active of these; it may be given in doses of 10, 15, or 20 minims, two or three times a day. Fowler's solution is to be given in doses of 3 drops, gradually increased to 10 or 12, beyond which we should never go. The Asiatic pills are used in the same old and rebellious forms of the complaint; one or two are given each day.

M. Devergie (whose work has already been reviewed in the GAZETTE) lays down the following rule as a guide to practitioners in the treatment of psoriasis:—

1. The arsenical preparations are, as a general rule, preferable to all others.

2. Antimonial and mercurial preparations sometimes do well, when the arsenical have failed.

3. When arsenical preparations have been employed in such doses, and for such a time, as ought to produce a radical cure, and the disease returns after a short interval, it is useless to employ arsenic again.

4. When relapses are frequent, a radical cure, even with the aid of arsenic, is very doubtful.

5. Arsenical preparations ought not to be employed in any very inveterate case.

6. The essential conditions necessary for the safe employment of arsenic are a healthy state of stomach and intestines, and a sound chest.

7. An individual disposed to diarrhœa or relaxed bowels cannot bear arsenic in sufficient doses, or for a sufficient time, to obtain a permanent cure.

8. Arsenic should not be employed in subjects affected with any chronic catarrh of the chest, asthma, or especially in young persons with a narrow chest, or in any case where we may think the development of tubercles possible.

9. Individuals of an opposite kind of constitution bear arsenic well—women better than men.

Bibliography.

Traitè des Fractures et des Luxations. Par J. F. MALGAIGNE, Professeur de Medecine Opératoire a la Faculté de Mèdecine de Paris; Chirurgien de l'Hôpital Saint-Louis; Officier de la Legion d'Honneur, &c. 2 vols., with an Atlas of Plates.

[This voluminous work has been very recently published, and as the opinions of so distinguished a surgeon as M. Malgaigne are deserving of every attention, we think it may not be unacceptable to our readers if we present to them, from time to time, extracts from this work relating to the accidents of the more important articulations. This we propose to do, not in the light of critical reviewers, but merely as translators, endeavouring to convey faithfully the opinions of the author.]

Dislocations of the Shoulder Joint.

These, according to Malgaigne, are met with under three forms:—Traumatic (or as we would term them, accidental), Pathological, and Congenital.

1. *Accidental Luxations.*—These are infinitely the most common, more common, indeed, than all the other luxations of the body taken together. They are much more common in men than in women; at the Hôtel-Dieu, of 321 cases, 87 only occurred in females.

The varieties of luxations of the humerus are numerous. Hippocrates knew only of one, that into the axilla. Celsus described two. In 1705, J. L. Petit described three luxations. Eighteen years afterwards he recognized the existence of four, which he thus designated:—

1. *Inwards*—into the axilla; according to him the most frequent.

2. *Forwards*—beneath the pectoral muscle; also very common, as he met with three examples of it in one month.

3. *Downwards*—on the inferior edge of the scapula.

4. *Outwards*—beneath the spine of the scapula. He also recognized an incomplete luxation.

Malgaigne asserts that experience has confirmed almost all the views of Petit; that they were not generally adopted, he thinks, is owing to the want of cases by Petit in support of his doctrines, and the love of changing names, which still prevails amongst authors. Dissections of old luxations, likewise, were wanting. Bonn (1782), Chopart, and Desault supplied this deficiency. As the result of these researches Desault recognized four forms of luxation:—

1. *Downwards*—on the edge of the scapula.
2. *Inwards*—between the subscapular muscle and fossa.
3. *Upwards*—behind the clavicle, *assez rare.*
4. *Backwards.* This division, adopted by Boyer, was for long the law of the French school. Sir A. Cooper rejected the dislocation inwards, changed once more the names of the other varieties, and, finally, revived, but differently from Petit, the idea of an incomplete dislocation. In 1828, says M. Malgaigne, "I was so struck with the contradictions which prevailed, that I endeavoured to obtain some more accurate facts by anatomical researches and experiments on the cadaver." He now became acquainted with the *subcoracoid luxations*, and from subsequent and more extended experience adopted the following classification. In the first place there are three great displacements:—

1. *Downwards*, or into the axilla.
2. *Inwards*, or forwards.
3. *Outwards*, or backwards. Each of these comprise important varieties. In addition there is a dislocation upwards. In all eight distinct luxations, which are thus arranged:—

Dislocations into the axilla:—

1. *Subcoracoid, complete*, very common.
2. *Subcoracoid, incomplete*, rare.
3. *Subglenoid*, rare.

Dislocations inwards:—

4. *Internal to the coracoid process*, the most common of all.

5. *Subclavicular*, rare.
Dislocations backwards:—
6. *Subacromial*, rare.
7. *Subspinal*, very rare.
Dislocation upwards:—
8. *Supracoracoid*; of this he only saw two examples (and one only from injury).

In practice scarcely any are met with except two, the *subcoracoid*, complete or incomplete (the axillary dislocation of other authors), and that internal to the coracoid process—(dislocation *inwards*, or *intra-coracoidienne*.)

These dislocations are then treated of separately:—

1. *The Subcoracoid Dislocation* (dislocation into the axilla), hitherto considered the most common, but first stated by Velpeau, in 1841, to be less frequent than the dislocation inwards. Observation has long led M. Malgaigne to adopt this opinion. Sir A. Cooper, he believes, has mixed up in his descriptions the symptoms of two dislocations (inwards, and into the axilla), and, hence, supposed the latter to be more frequent than they really were.

The *mechanism* of its occurrence is stated to be the following:—A person falls on the hand, or on the elbow, when the arm is separated from the side, and forced elevation of the arm is produced. What occurs then is as follows:—The long tendon of the biceps, gliding in the bicipital groove, directs this groove towards its own upper insertion, so tha the great tuberosity comes to rest, behind the tendon, on the glenoid border; normal elevation ends here. If this limit is overstepped, the humerus acts as a lever of the first order, whose fulcrum is at the contact of the tuberosity with the glenoid border; the resistance is at the inferior and anterior part of the capsule, which is torn; the movement of elevation continuing, the neck of the humerus is driven against the acromion, and there finds a new "*point d'appui*," which disengages the tuberosity from the glenoid edge, and throws the head of the humerus downwards and forwards.

This dislocation is always readily produced in the dead subject by resting either the acromion, or the axillary border of the scapula, against the edge of a table, and causing forced elevation of the arm. In the living subject this fixiety of the scapula is produced by the muscles, and this he believes to be the only share they have in producing the luxation; but the accident may be produced in other ways, but more rarely, as by sudden elevation of the arm, &c. We pass on to consider the

Symptoms.—The head and the body are generally inclined towards the affected side, the arm separated from the body, and the forearm supported by the opposite hand, or by a sling. There is pain in the shoulder, and inability of raising the arm; the point of the shoulder is flattened, the acromion prominent, whilst beneath it is a depression, into which the finger sinks towards the glenoid cavity. In the armpit, almost on a level with the skin, the fingers can distinguish the rounded prominence of the head of the humerus, at the same time a slight prominence can be distinguished in front, which partly effaces the subclavicular fossa; here, through the thickness of the muscles, the head of the bone can be felt immediately below the coracoid process, in front of which it also projects. The point of the process can be easily felt dividing the head, as it were, into two equal parts. This wall of the axilla is sensibly lengthened, the arm also seems longer, the elbow is separated from the side, and is sometimes carried backwards; generally the humerus is *rotated outwards*, so that the *epitrochlea* looks inwards and forwards, and the *epicondyle* backwards and outwards. The patient is able to move the arm slightly forwards and backwards, but such motions are excessively limited even to the hand of the surgeon. On the contrary, the patient is wholly unable to raise the arm by any voluntary effort, but it can easily be elevated by communicated motion. The elbow cannot be brought in contact with the side.

This last symptom is due to the tension of the superior and posterior portion of the capsule which remains uninjured, and is equally observed in the dead body. The same circumstance accounts for the elbow being carried backwards, and for the rotation of the humerus. These phenomena are more marked in the robust subject, in whom the coracoid process being larger forces the head of the humerus to descend lower.

The flattening of the shoulder, prominence of the acromion, with the hollow beneath it, are symptoms common to almost all the dislocations of the shoulder, and are owing to the deltoid losing the support of the head of the bone. The length of the dislocated limb has been the subject of controversy. Lengthening of the limb was first observed by Celsus in dislocations into the axilla, and was subsequently noticed by most surgeons; but it was carelessly observed, as for example, by Boyer, who only examined the level of the two elbows from behind. Others only admitted its existence in the dislocation downwards. M. Malgaigne claims to have established, in 1830, that *in all the dislocations of the humerus the arm is lengthened.* Errors, we learn, are very apt to be made, unless the measurements are very carefully taken. The difference in length is always more remarkable along the front of the limb than the back.

Appearances on Dissection.—In a recent case (in 1830) the following appearances existed. The head of the bone lay immediately beneath the coracoid process; the anatomical neck of the humerus lay on the glenoid border, and the great tuberosity rested on the internal and inferior part of the glenoid cavity. The capsule was torn from the humerus anteriorly, and was reflected, so that the head of the bone lay bare in the axilla, between the lower border of the subscapular muscle and the tendon of the latissimus dorsi; the subscapular muscle covered its inner and upper portion; the coraco-brachialis lay upon it in front; the nerves and vessels, elevated by the head of the bone, lay internal and in front of it. The term *sub-pectoral*, proposed for this luxation by M. Velpeau, was thus shown to be incorrect. The muscles which covered the head of the bone in front were the coraco-brachialis and the biceps; the pectoral muscles had no direct relations with it. In addition, the long tendon of the biceps, at its exit from its groove, was applied upon the glenoid cavity, and the back of the capsule was stretched over this cavity, as were the tendons of the supra and infra-spinati muscles; the edges of the subscapular and teres major muscles were partly torn, from the head of the bone having been forced through the narrow button-hole formed by these muscles. Of all the muscles, the subscapular was the most stretched, having to follow the *contour* of the head of the humerus in order to reach the lesser tuberosity.

These appearances are those most usually met with, and, according to Malgaigne, may be taken as typical.

The *diagnosis* in reality presents no difficulty, unless there be immense swelling, or inordinate *embonpoint.* Three symptoms exist, which are pathognomonic; the others are auxiliary to these. Thus, there is a depression beneath the acromion, a certain sign of a luxation; the head of the humerus can be felt in the axilla, without the necessity of separating the arm from the side—the contrary has been incorrectly stated by Sir A. Cooper—a sure sign of an axillary dislocation; lastly, the coracoid process can be felt related to the upper part of the head of the humerus, which projects equally on the inside and outside of this process—the sign of a subcoracoid luxation. This dislocation has been mistaken for a fracture; Dupuytren even committed this error. Fracture of the neck or of the head of the humerus only could be confounded with a luxation, and this only when the lower fragment is displaced into the axilla. In fracture of the neck, the head of the bone remains in its place, and the depression is not immediately beneath the acromion, but lower down. In fracture of the head, the depression is immediately below the acromion; and, although less pronounced, might lead to error: but, then, in the first place, the subcoracoid luxation always produces lengthening of the arm—the fracture is invariably attended with shortening; and, in the second place, the axillary tumour, in the case of fracture, never presents the roundness of the head of the humerus.

2. *Incomplete Subcoracoid Luxation.*—Petit was disposed to admit the occurrence of partial luxations of the humerus, and supposed that such were the cases which quacks in his time boasted to be able to reduce by a *tour de main.* Chopart and Duverney allude to the subject vaguely; so that Sir A. Cooper was the first to give any special account of partial luxations. According to him, the head of the humerus may be dislocated *on the outside of the coracoid process;* but independently of the fact that there is not room enough for the head of the bone to lie in that situation, we find that, in the three cases brought forward in support of this view, two are manifestly luxations *beneath* the coracoid process; whilst the third, which alone agrees with his description, is nothing more than a *pathological* subluxation. In 1835 Malgaigne showed that there was an incomplete luxation, in which the head of the humerus was placed beneath the coracoid process, but still rested on the anterior edge of the glenoid cavity, a portion of it still looking towards that cavity. South published a case in which an examination of the parts was obtained a few days afterwards: the bone had been reduced, but the luxation was easily reproduced. The following were the appearances:—The capsule anteriorly presented a rent about an inch long; the head of the humerus lay on the anterior edge of the glenoid cavity, and had not entirely escaped from the capsule; the coracoid process was broken half an inch from its extremity—this fragment was drawn down by the short head of the biceps; lastly, other fractures existed of the acromion process, and of the clavicle on the same side. In publishing this curious case, South said that partial dislocation of the humerus could not occur without fracture of the coracoid process. Malgaigne, however, has seen it without any such fracture, but with slight *splintering of the glenoid border.* The capsule likewise was but slightly torn. Pinel long ago also described such a case. "The head of the humerus," he said, "had only in part abandoned the glenoid cavity, and rested on the inferior part of its inner border, closely applied against the outer edge of the end of the coracoid process; the capsule was but slightly torn." In some cases of old partial luxation, the glenoid edge imprints a deep groove on the head of the humerus, marking the precise point where the displacement of the head of the humerus was checked, and where the subsequent action of the muscles only fixed it the more firmly. Malgaigne observes that this accident can be produced in the dead subject by drawing the head of the humerus downwards and forwards, *without even rupturing the capsule,* and in the living is often produced by force applied directly to the shoulder.*

The *symptoms* have been but little studied, this luxation having been generally mistaken for some of the other varieties. In some cases the bone is so little displaced that the luxation may be reduced almost before it is recognized. Where the displacement is more decided, we have almost all the symptoms of the complete subcoracoid luxation. However, the fulness in front below the coracoid process, is nearer the joint, and the depression beneath the acromion exists only behind.

The *diagnosis* demands serious attention. When there is but slight displacement, the case may be looked on as a contusion merely, or perhaps as one of fracture within the capsule. Chopart supposed such a case to be one of displacement of the biceps tendon. Malgaigne here observes that, except where the humerus is broken or luxated, he has *never known this tendon to be displaced from accident.* By the relation which the head of the bone bears to the coracoid process, we can easily decide if a luxation be complete or incomplete. In recent cases the reduction is easily effected; even after very long periods, as eight months, it is probable that most of the luxations of this variety can be reduced. Malgaigne met with one notable exception. The bone was luxated for six months and twenty days; extreme extension was employed along with the knee in the axilla; the head of the bone seemed to go half into its place, but could not be got further. Tetanus was the result, which proved fatal eight days after the ineffectual attempts at reduction; and on examination a mass of fibrous tissue was found to form the upper part of the new capsule, whilst posteriorly the old capsule was much retracted, and so adherent that there was no longer room for the back part of the head of the humerus.

(*To be continued.*)

Die Lehre vom Auswurf. Von Dr. Anton Biermer, Vormals Assistenzarzt der Medicin. Klinik am Juliusspitale zu Würzburg.

In the preface to the work before us we are informed that, in the year 1849-50, the Medical Faculty of Würzburg crowned with a prize an essay on the subject of expectoration, by Dr. Biermer.

The publication of this work our author postponed, with a view of availing himself of the opportunities presented to him as clinical assistant physician in the Julius Hospital, at Würzburg, of extending his observations and maturing his opinions upon the subject, the successful prosecution of which had previously gained for him such high distinction. A perusal of Dr. Biermer's brochure will afford evidence of the excellent manner in which he has employed the rich materials with which he was furnished. The importance of an accurate examination of the sputa in disease, and the value of the information thus obtained in the prognosis, diagnosis, and treatment of various lesions, is universally acknowledged by all practical physicians, and by many this examination is made with much care and precision, but in truth we must admit that too often this mode of proceeding is not adopted.

The investigation of the sputa, in a number of cases, is loosely conducted, and the inferences deduced vague and unsatisfactory. Nevertheless, we may refer to the works of many writers, both ancient and modern, who have devoted due attention to this subject. In obscure thoracic disease how often does the character of the expectorated matter throw light upon the nature of the affection, and conduct us to a correct diagnosis?

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* A case presenting somewhat similar features was brought before the Dublin Pathological Society, at its meeting, December 15th, 1849, by Mr. Adams. A woman, 65 years of age, presented the ordinary symptoms of dislocation of the humerus forwards. "The head of the bone was replaced without difficulty." She died of the effects of another accident a month afterwards; and, on examination of the joint which had been luxated, it was found that part of the front tuberosity had been broken off; none of the muscles were torn; *the capsule had not been ruptured,* but *a portion of the inner margin of the glenoid cavity had been torn off.* There was pus in the joint, and other signs of acute inflammation.

The notes of a case, in the handwriting of John Hunter, is, in the same communication, also alluded to. Dissection, three weeks after a luxation had been reduced, showed ecchymosis of the subscapular muscle; the capsule uninjured; but the inner cartilaginous border of the glenoid cavity broken off. "Here," adds Hunter, "was a case of *undoubted dislocation,* and yet the capsular ligament was *not torn* when the luxation was effected, although it must be supposed that the giving way of the cartilage at the edge of the glenoid cavity admitted the ligament to yield more than it otherwise would. Although the ligament was not torn so as to let the head of the bone escape through the rent part, *yet the head of the bone was certainly out of the socket;* and, from all the appearances and circumstances taken together, how it got there without doing more mischief, I do not understand."—*Catalogue of the Royal College of Surgeons, England.*

In the splintering of the inner edge of the glenoid cavity, and the occurrence of luxation without the escape of the head of the humerus from the capsule, these two cases closely resemble those which Malgaigne classes as partial subcoracoid luxations.—Translator.

In our days the fluids are receiving an amount of attention, from which they had been long debarred, and with all the aids and appliances of modern science, we may expect great results, in addition to the numerous and interesting facts already accumulated. Before entering upon the subject matter of his work, Dr. Biermer reviews, in the form of an historical introduction, the labours of those who have preceded him in this field of inquiry, and as this portion is replete with interest, we propose to devote to it a passing notice. We were well aware, before we engaged in our present task, that the expectoration (by which we mean the matters ejected from the air tubes) had played a much more important part in the semiotics and prognostics of the ancient physicians than in those of their modern successors. Having a reverence for ancient authorities in physic, we had long been familiar with all that Hippocrates has said on the subject of the sputa. We could call to mind the reference to the sputa in his aphorisms, a work which has been designated "a performance surpassing the genius of man." Subsequent observers have, in numerous instances, confirmed the accuracy of the statements respecting the diagnostic value of different kinds of sputa made by Hippocrates.

We find that he laid much stress upon the presence of pus in the expectoration as a sign of evil import, a dogma to which such weight was attached for so long a period.

For the purpose of ascertaining the presence of pus, he directed that the patient should spit into sea water, and by the sinking of the sputa he was satisfied of their purulent nature. An unfavourable prognosis was formed in phthisis (11th Aphorism) if the sputa emitted a heavy smell when poured upon coals.

An excellent and truthful description is given of tubercular expectoration, the round purulent sputa, those tinged with blood, the granular sputa, &c., &c. Bloody expectoration Hippocrates looked on as the precursor of purulent. The ill-smelling, dirty, black sputa, as if coloured with red wine, closely agree with what we meet in gangrene of the lung. Absence of expectoration in pneumonia and pleuritis, or the sudden suppression of sputa, were looked upon by Hippocrates as warranting an unfavourable prognosis. Many allusions are made to critical expectoration in the Hippocratic writings.

We might adduce numerous instances in which an extraordinary amount of knowledge of the various modifications of the sputa, met with in disease, is displayed by Hippocrates, but we must pass on and briefly notice those who humbly followed in his wake.

The statements of Celsus have little of originality, and indeed are, in part, translations from Hippocrates.

Dr. Biermer states, with truth, that the remarks of Aretæus, on the expectoration, are interesting and original, and that his treatise on Hæmoptysis is a model of sound observation. Many of the rules laid down by Aretæus, particularly with reference to the characters which distinguish hæmoptysis from hæmatemesis, remain in full force at the present moment. It may be said of Galen, the distinguished commentator of the works of Hippocrates, that in his views of expectoration he closely followed his great exemplar.

The greater number of medical writers who follow immediately, and to whom Dr. Biermer refers, seem to want all originality, being merely compilers of the experience of their predecessors.

Alexander Trallianus evinces more self-dependence; he gives certain tests by which pus may be discovered in the sputa, and he relates a case in which calcareous masses were coughed up, which, when thrown on the ground, produced a noise. We believe Trallianus is the first author who has called attention to the presence of tophacious substances in the expectoration. From his time frequent mention is made of them by almost every pathologist. The case adduced by Trallianus was most probably one of *cured phthisis*.

For those who take an especial interest in this matter we would refer to the writings of Morgagni, Bonetus, Cullen, Bayle, Laennec, Stokes, Bennett, &c., &c.

With regard to the origin of calcareous productions, various theories have been broached, some of which are scarcely worthy of notice. One of the most extraordinary and untenable was that of Cullen—viz., that they were caused by the substances diffused through the air which is breathed by various artisans. The presence of calcareous bodies in the lungs was supposed by Bayle to be one of the *causes* of phthisis. The opinion of recent writers on thoracic disease seems to us well founded, inasmuch as we have ourselves repeatedly verified their views. Dr. Stokes says, "I have observed several cases of calculous expectoration, in which a great quantity of tubercle seemed to have undergone cretaceous transformation." Professor Bennett, of Edinburgh, in his work on the Pathology and Treatment of Pulmonary Tuberculosis, looks upon "the gradual transformation of the exudation as one of the modes in which the arrestment of tubercular ulceration may take place."

To return to Dr. Biermer's historical sketch. Paulus, of Ægina, gives a description of a case of empyema, in which a communication was formed between the pleura and the lung, and which terminated by purulent expectoration.

Then comes Avicenna, who made use of Hippocrates, Galen, Aretæus, and Paulus Ægineta, and whose description of the sputa clearly shows the sources from which it was derived.

We do not find any observations worth recording by the writers of the Arabian School; even the most illustrious, Rhazes, does not give anything new, his views were Galeine, and derived indirectly through Oribasius. At the extinction of the Saracenic School may be said to commence that period, denominated the dark ages, during which, from the 12th to the 15th century, medicine, like all other sciences, stood still, or more truly retrograded, having fallen into the hands of ignorant monks, who were the sole depositories of the little learning which existed in this epoch of mental debasement. In the centuries immediately following, the Hippocratic and Galenic views prevailed to a great extent; there were, however, some independent observations made on expectoration.

Dr. Biermir proceeds to notice the works of Joh. Fernelius, one of the most eminent physicians of the 16th century, of Jodocus Sommius, of Baltonius, and of Dodonæus, and from the latter he quotes the following from his chapter "De Calculo Pulmonis"—"Generosus ac illustris quidem Baro calculum sæpe cum sputo excrevit, qui in extremis asperæ arteriæ ramulis ac propaginibus natus loci figuram referebat: forma oblongus teres tenuisque calore candidus." In the year 1601 appeared the work of Prosper Alpinus, "De præsagienda vita et morte ægrotantium," in which a most lucid description is given of the varieties of sputa, and which, in accuracy, excels that of any preceding author. It may, with advantage, be transferred to our pages—"Sputa indicia sunt affectionum tum pulmonum, tum theracis, tum asperæ arteriæ, tum gutturis atque ut in summa dicam, respirationi subserventium instrumentorum omnium. Differunt vero inter se substantia, figura, colore, quantitate, simplicitate, et mistione, odore, sapore exscreationis facilitate atque alleviatione aut auctione doloris atque tussis. Substantia enim tenuia sunt, crassa viscida et visciditatis expertia. Figura plana, æqualia, rotunda, spumosa, cruenta et purulenta. Colore alba, pallida, flava, rufa, rubra, viridia livida, nigra et quædam versicolora. Quantitate vero multa, pauca et nulla. Simplicitate ac mistione, simplicia mera vocata, atque mista. Odore, ægreolentia et quæ non male olent. Saporibus, insipida, dulcia, salsa, amara et acria. Facilitate exscreationis et difficultate, quæ facile tussi rejiciuntur, quæ difficulter et quæ nullo modo. Quæ dolorem et tussim sedant et quæ augent, ac demum concocta, cruda atque maligna."

Passing over many names we are attracted by our own

Sydenham, who has particularly directed attention to the sputa in small-pox and pleuritis. He considered bloody sputa in small-pox, when the pustules are not formed, as a truly lethal sign.

Dr. Biermer considers the description given by Morton of phthisical expectoration excellent for its time (1689). He speaks of the expectoration coloured by black pigment, and looks upon it as a forerunner of phthisis. Ruyschius' (1696) mentions a bronchial polypus which had the form of a bronchus with its ramifications. We believe no previous notice had been taken of this comparatively rare affection—plastic bronchitis. Ruyschius says, in *Catalogo Rariorum Musei sui*,—"Quo ipso multi fuere decepti in pectoris affectibus, cum tussiendo tales polypos ejecerunt, credentes sese venas expectoratas ostendisse." Gurish, in his work published in 1729, refers to a peculiar kind of sputa observed by Reisselius, which appeared as if coloured with indigo.

The views of the eighteenth century on the subject of expectoration are best learned by turning to the labours of Boerhave. Marked attention was paid to the sputa by the school of Boerhave, as we learn from his writings, and the great work of his pupil, Van Swieten. The latter says,—"The sputa, in all cases of disease of the chest, are deserving of the utmost attention, for they come direct from the lungs, and they are separated from the blood of the entire body which passes through them." Dr. Biermer gives the observations of Boerhave and Van Swieten at length, as they represent the views of their age, and he disposes of the writers of the eighteenth century briefly in these words:—"What we find in the works on semiotics, and in the special treatises on the sputa, which appeared in the eighteenth century, is nothing more than a mere compilation, and devoid of any importance."

Towards the end of the eighteenth century much interest was taken in the inquiry relative to the characters which distinguish mucous and purulent sputa, and this seemed to exercise an influence on the doctrine of expectoration. In the year 1780 our countryman, Darwin (in consequence of the Edinburgh Medical Society having offered a prize for an essay on the subject), endeavoured to prove the inadequateness of the previously existing tests, and proposed a new one for distinguishing between mucus and pus. According to Darwin, pus, when added to dilute sulphuric acid, formed a cloudy fluid, and deposited a sediment, and mucus on being heated with corrosive sublimate, becomes coagulated into a hard mass, which is not the case with pus. Michaelis, in the year 1784, questioned the correctness of Darwin's experiments, and induced his pupil, Salmuth, to publish in his dissertation, "De Diagnosi Puris," a refutation of all the known tests for pus. We now arrive at a period when a new stimulus was given to all scientific investigations.

In the nineteenth century clinical medicine, and the auxiliary sciences, have made unwonted progress, and the sputa have received a large amount of attention as an aid in the diagnosis of disease. The physical examination of the chest has, in addition to the numerous benefits it has conferred, added to the importance of a critical examination of the sputa in a semiotic point of view, &c. The introduction of chemical and microscopic investigation had the effect of shedding much light upon many points connected with the sputa hitherto utterly unknown, and thus establishing the value of the inquiry connected with its relation to various morbid states of the system. As to date we find that the chemical preceded the microscopic examination of the sputa. In the *Medical and Surgical Journal* of Edinburgh, Dr. Munro, jun., published a case (1805) of hepatitis with biliary expectoration, in which a chemical examination was made by Dr. Duncan.

Pearson, also, in the Philosophical Transactions (1809), made public his chemical researches on expectoration, and, in the same year, Gruithnisen published his investigations on the difference between pus and mucus, and dwelt especially on the importance of microscopic observations.

The years 1837-38 were rich in contributions to the literature of the subject of expectoration, and among the many names of the authors, whose works appeared at this time, we may mention Vogel, Heule, Gütterbock, Gluge, Valentin, and Gruby. Dr. Biermer does not think that their labours exercised any especial influence on diagnosis. Heule, however, opened out new views, establishing that there does not exist any morphological difference between the mucous and pus corpuscle, and agreeing with Vogel in considering pus corpuscles as diseased epithelium cells.

Gütterbock gave the first good description of the chemical and microscopical characters of the expectoration. In this abstract, which we have made from Dr. Briermer's "Historical Introduction," we have passed rapidly under review the subject of expectoration, from the early periods in the history of medicine down to our own time, which we shall find (when we come to place before our readers a *resumé* of Dr. Biermer's work) abounding in contributions to the knowledge previously possessed on this important point in clinical medicine.

SELECTIONS FROM BRITISH AND FOREIGN JOURNALS, &c.

Dislocation of the Foot forwards, uncomplicated by Fracture.

[The following case of this rare accident was communicated to the *Société de Chirurgie*, by M. Huguier, of the *Hôpital Beaujon.*]

The patient was a man of thirty-four years of age, and was admitted into the hospital, August 31st, 1855. He had been employed about some works connected with one of the railways, when his left foot became entangled between the spokes of a horizontal iron wheel beneath the metal plate of a "turn table." One of the spokes pressed on the front of the leg, a little above the ankle, and the foot and leg were drawn in opposite directions, as the wheel was moved on by the force of six other workmen; the foot was drawn forcibly forwards, and at last the sole of the shoe was torn off, but not until the foot had been luxated forwards.

The most remarkable symptoms were, elongation of the foot and disappearance of the heel; the dorsum of the injured foot measured two centimetres more than the sound one. The hollow above the heel was obliterated, and the lateral fossæ were filled up; the back of the leg and the heel were in a straight line. The upper surface of the astragalus was very visible in front of the tibia. The malleoli lay behind the corresponding articular surfaces of the astragalus; the external malleolus was by far the most prominent; there was no fracture of the malleoli; the skin covering them presented marks of ecchymosis.

Chloroform having been given, the reduction was easily effected by pressing the foot directly backwards. By means of a bandage acting like a stirrup, the foot was kept at right angles with the leg. In eight days this was removed, and the patient was able to move the foot easily and without pain. A few days afterwards he was able to walk. M. Huguier observes that dislocation of the foot forwards is extremely rare. Malgaigne* says he knows of but five instances that have been recorded by Colles, Nelaton, Pirrie, and R. W. Smith. In all these, except in the one reported by Pirrie, there was fracture of the anterior border of the tibia, or of one or of both malleoli. In the case now recorded the luxation was perfectly simple, owing to the peculiar manner in which the accident was produced.—*Gazette Medicale.*

[The last paragraph is taken from Malgaigne, but is not quite correctly given. Malgaigne observed that in the cases recorded the fibula was uninjured; "the tibia," he says, "suffers more. M. Nelaton saw its anterior border fractured. In the case recorded by R. W. Smith, the point of its malleolus had lost its form and was *probably* broken. In Colles's case a large mass of callus at the back of the tibia announced a fracture of the lower end of that bone. Pirrie alone declared that (in his case) both the malleoli were uninjured." It thus appears that whilst in dislocation of the foot backwards (*tibia forwards*), the fibula is generally, if not always, fractured, in the dislocation of the foot forwards, when complicated with fracture, it is the tibia and not the fibula which is thus injured. Professor Smith† objects to the nomenclature of these injuries adopted by the French writers, who speak of the foot being dislocated forwards, backwards, or laterally, for the foot, he says, "must be fixed before the luxation either forwards or backwards can occur. It is therefore," he adds, "manifestly improper to designate these from the part which is immoveable at the time, instead of naming them from that component of the articulation which, in reality, does move from its normal position, namely, the tibia." However, in the present instance, the term dislocation of the *foot* forwards is correctly applied, for owing to the peculiar mode in which the accident occurred, the luxation was produced by the foot being drawn forwards, the leg being at the moment immoveable. The foot likewise was fully *extended* at the moment of the luxation. In Professor Smith's case, the foot was in a state of extreme *flexion*, and the force being applied to the upper part of the limb, the tibia was consequently driven backwards.—ED.

Report of Cases of Laryngotomy. BY HENRY THOMPSON, F.R.C.S., M.B.

The following cases are, I think, worth recording, inasmuch as they bear on the question of employing laryngotomy in place of tracheotomy in circumstances of impending death by asphyxia from laryngeal occlusion; a question which, during the last few years, has been receiving a practical solution in the successful substitution, in many instances, of the simple and easy operation for that which is not unfrequently both dangerous and difficult of performance.

CASE 1.—I was called, at four o'clock in the morning of the 27th of September, by Mr. Joseph, of Manchester-street, to see a patient, to whom he had been summoned two hours previously. I found a man of about forty years of age, lying on his back in bed, with extended neck and livid countenance, gasping for breath. An attack of acute laryngitis had supervened on an ordinary cold in the course of the previous day, had been vigorously treated by applications of ammonia, &c., but was now threatening to prove fatal by asphyxia. There was no time for delay, and, with Mr. Joseph's concurrence and assistance, I proceeded at once to make an opening into the larynx. Having made a short incision through the skin, in a vertical direction, over the crico-thyroid membrane, I found it necessary to tie a small artery, which spouted freely on dividing the tissues beneath. The membrane itself was then incised to an extent sufficient to admit a full-sized double trachea tube, which was inserted and adjusted without the slightest difficulty. The relief was instantaneous. A few very forcible inspirations and expirations followed, the lividity vanished, and the patient was soon in a sound and comfortable sleep. A piece of muslin was folded three or four times and laid on the orifice of the tube, to modify the temperature of the inspired air.

I saw him once a day on the three following days, during which he was recovering rapidly. The tube did not cause the slightest pain or irritation. Meantime, Mr. Joseph's assistant removed the inner tube twice a day, in order to detach the adhering viscid mucus, and returned it each time well oiled within and without. I have often had occasion to observe before that this application tends to retard the accumulation considerably.

On October 1st, the fourth day after the operation, finding that the patient could speak well when the tube was closed, and that there was scarcely any tenderness about the larynx, I removed the apparatus, approximated the edges of the small wound, and applied water dressing.

On the 8th of October the wound had entirely closed, and on the 10th the patient walked out, and, with the exception of debility, had recovered from the attack.

CASE 2.—On June 2nd, 1854, I accidentally met in the Strand a well known physician, who had just been summoned to a case of urgent asphyxia, and who requested me immediately to accompany him. We found a little boy, three years of age, livid and almost insensible, struggling violently for breath. There was evidently no time to be lost. Not being provided with the necessary appliances, I ran into the shop of Weiss, the instrument maker, fortunately only a few doors off, and instantly obtained them. Opening first the crico-thyroid membrane, I found it necessary subsequently to divide the cricoid cartilage and upper ring of the trachea, in order to introduce the tube. Before, however, this could be accomplished, he had almost, if not quite, ceased to breathe, a significantly long interval having been noted during the last two inspirations; and it was not until we had performed artificial respiration, in part by applying the mouth to the tube, but chiefly by performing repeated acts of pressure upon the abdomen and ribs, that the natural action of the lungs was established. We had the satisfaction, however, of leaving him, in the course of half an hour, completely relieved, and enjoying comfortable sleep.

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* Traite des Fractures et des Luxations, tom. ii., p. 1019.
† Proceedings of the Pathological Society, vol. ii.

June 3rd.—We saw the patient together. He was breathing comfortably, taking nourishment freely, and in all respects improving. A good deal of mucus was passing through the tube.

I subsequently learned that, contrary to express orders, the tube was removed for a short time by the attendants of the child, on the 5th inst., and that in this condition he suddenly died of asphyxia, in less than ten minutes after taking, with considerable relish, a basin of beef tea. No *post mortem* was admitted.

These cases are practically valuable, inasmuch as they present additional evidence in favour of an opinion the accuracy of which is becoming more and more apparent, namely, that a tube may be introduced into the interior of the larynx, and be retained there for some time, without exciting irritation of the organ, even in the presence of acute laryngitis; and that it is therefore unnecessary to resort to the severer method of tracheotomy, on the assumed ground that it is calculated to occasion less disturbance to an already diseased larynx.—*Lancet.*

Dislocation forwards of the Tibia; Impossibility of retaining it in situ *by the ordinary Means; successful Employment* (de la pointe) *of the Clamp.*

Upon the 27th of May, Pierre Narro, 27 years of age, received from one of his comrades a violent blow on the external malleolus. He felt something give way, without any very acute pain, and immediately fell. He endeavoured in vain to raise himself, and was then carried to the *Hôpital St. Louis.* Upon his admission his foot was found slightly extended and everted; some swelling obscured the parts; it was ascertained, however, that there was a point very painful upon pressure, anteriorly and externally between the tibia and fibula, the external malleolus was carried backwards, and separated from the extremity of the tibia, which was displaced forwards by a distinct interval, which was partially obliterated by the adduction of the foot. The extremity of the tibia was prominent anteriorly, but it was so concealed by the swelling as to be with difficulty seized. Upon the following day, at the visit, M. Malgaigne diagnosed an incomplete dislocation of the tibia forwards, with fracture of the inferior extremity of the fibula, and reduced it immediately by forcibly bending the knee and pressing the heel forwards; at the same time he observed that he had never been able to maintain a displacement of this kind in its place, without the aid of the clamp; but as other surgeons differed from him in this opinion, he engaged M. Richard to employ other means in the first instance. From the 28th of May to the 3rd of June, M. Richard, with the assistance of the interns, applied different kinds of apparatus, viz., straps, bandages, and splints; but in spite of all the various arrangements they could think of, they found it impossible to maintain the luxation *in situ;* and at the end of twenty-four hours they always found the tibia protruding in front. Upon the 3rd of June, M. Malgaigne applied the clamp; the patient did not suffer much pain, either during or after its application; the luxation was perfectly reduced, and the swelling, which had remained since the admission of the patient, disappeared upon the following day. Upon the 9th of July the clamp was raised; no suppuration had taken place. Upon the 24th the patient began to walk about upon crutches. Upon the 12th of August he demanded his dismissal. He still went about upon crutches; but was able to place the injured foot upon the ground without pain. The flexion of the knee was perfect, but the movement of the ankle caused pain, both in the joint and in the wound caused by the clamp. Upon the 21st he visited the hospital, walking without crutches, the wound healed, and the movements of the tibio-tarsal articulation perfectly free.—*Gazette des Hôpitaux.*

THE IRISH MEDICAL DIRECTORY.

We beg to direct the attention of our Subscribers to the circular which they have received from the Publishers of the *Medical Directory*. It is of great consequence that it should be correctly filled up, and returned immediately. It is not creditable to the Irish medical public that this valuable periodical was not published last year, in consequence of the very limited number of subscribers. We trust that the Publishers will receive, on the present occasion, such encouragement as will warrant their not only publishing, but increasing its utility.—Ed. D. H. G.

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A Subscriber is informed that the medicine is patented; the formula is not made public.

_J. L._—The subject you mention is under consideration; if possible the plan will be adopted.

DUBLIN: PUBLISHED BY W. B. KELLY,
8, GRAFTON-STREET.
LONDON: S. HIGHLEY, 32, FLEET-STREET.
EDINBURGH: MACLACHLAN & STEWART.
November 1, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.
SENT FREE BY POST.
Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 20.—Vol. II. NOVEMBER 15, 1855. Price 5d.

Introductory Lecture delivered at the Carmichael School of Medicine, Nov. 2, 1855.

BY JOHN HAMILTON,

SURGEON TO THE RICHMOND HOSPITAL.

Gentlemen,—In an introductory lecture which I had the honour to give in this School some years ago, I endeavoured to show that in the last fifty years surgery had advanced in an equal proportion with other arts and sciences, and that the improvements which had taken place in other arts and sciences had even been beneficial to surgery. That lithotrity, the invention of Heurteloup and Civiale; the cure of aneurism by compression, which we owe to Todd and Hutton, and for which the Dublin School has reason to be proud; the use of æther and chloroform in lessening the pains and terrors of operations, the happy discovery of Jackson and Simpson; and many other medical improvements during that period, had been real boons from our profession to mankind. That besides these, surgery had received an impulse for the better generally, an increased simplicity in practice, and such a superior knowledge in the treatment of diseases of the bones and joints, that limbs, formerly considered incurable and condemned to amputation, are now saved; such a judicious handling and care of fractures, that the amputating knife, formerly in constant requisition, is now put aside by the more skilful hand of the modern surgeon. The medical studies which form so large a portion of the surgical student's education, have tended much to raise the position of the surgeon. The mere surgeon is now so little in demand by the public, that such a person is hardly found to exist. Although in the interval of five years there has been no very striking invention, causing as it were a revolution in some branch of our art, surgery has not been at a stand-still. It is not my intention on this occasion to go *seriatim* into what has been done in that period, but I may hint at one or two innovations. Among them, I think the recent improvement in the reduction of dislocations of the thigh will be found most important, in substituting skilful and ingenious manipulation for force.

Sir A. Cooper laid it down that it was best not to waste time or wear out the patient by attempts at reduction by manual efforts, the great resistance of the powerful femoral muscles nearly invariably causing these attempts to fail.

Tartar emetic, bleeding, and a warm bath at a very high temperature, were first to be used to lessen the force of the muscles; and then powerful, steady traction with the pullies was to be chiefly relied on to bring the bone back to its articulating socket.

It has lately been found that chloroform reduces to such an extent the muscular action, that not only manual exertions, but manual exertions of comparatively small force, are sufficient to reduce the dislocation. From seven successful cases of different kinds of femoral dislocations I select the following:—A woman, aged 29, strong and in good health, fell from a window to the ground. Mr. Birkett saw her about two hours after the accident, when every indication existed of the head of the left femur being situated upon the dorsum of the ilium. Chloroform was administered; a round towel was adjusted close above the knee, and the dresser, Mr. Newenham, made direct extension therewith, his foot being placed against the pubes. In this instance immediately all muscular contraction ceased, the head of the thigh-bone was heard to enter the acetabulum with a loud noise, accompanied by a violent jerk.

But Mr. Cock, of Guy's Hospital, uses even less exertions than these. When the patient is fully under the influence of chloroform, so that the limb can be moved freely about, he seizes the thigh, bends it on the pelvis, then abducts it, rotating outwards at the same time, and the head of the femur usually slips into the acetabulum, over the edge of which this manœuvre has lifted it. Five weeks after dislocation, and when the pullies had been already resorted to, Mr. Cock thus succeeded in accomplishing the reduction. Without chloroform this plan would be of no avail.

Since I last addressed you, a most interesting discovery has been made of the property of a solution of the perchloride of iron, to produce coagulation of the blood. M. Pravas was the first to find out this important fact; but he used too strong a solution—a concentrated one. M. Geraldès has made a number of experiments with great care. He found that a drop or two of a solution of the perchloride of iron injected into the carotid artery of a horse produced coagulation in it for a certain distance; that this primary clot was succeeded by secondary clots in the vessel at either end of the first clot; a change is also induced in the middle and external coats of the artery itself. If the solution is too strong, the effect on the coats of the vessel is too powerful, like a process of tanning, they lose their vitality and mortify. For injecting into aneurisms, he recommends a solution of twenty degrees, or at most thirty; a peculiar instrument is required for the injection—a small syringe, acted on by a screw, so that the quantity can be regulated with the utmost nicety. I have had hitherto no case adapted for a trial of this powerfully coagulating property of the perchloride; but I believe it will prove of value in aneurisms, anastomotic tumours, varices, and the like.

We must not be surprised that novelties do not start up every day. Important discoveries in our own as well as in other arts are rare; a genius of a peculiar kind, a particular bent of the human mind at the time, a certain relative position of the inventor, are all required. A great invention is hardly ever accidental. The boiling kettle, which suggested to the mind of Watt the invention of the steam-engine; the falling apple, which originated the stupendous discovery of the law of gravitation to Newton, had been heedlessly and unprofitably witnessed for ages by millions. But Newton and Watt were not only men of genius, but accustomed to long previous habits of study and of thought in the peculiar tract of such inventions. What vast chemical knowledge, what laborious investigations, preceded the discovery of the safety-lamp by Davy! America was not accidentally found by any ignorant mariner. Columbus was one of the boldest seamen and best geographers of his age; and by reasoning, founded on extensive knowledge, he came to the clear conviction of the existence of a new world in the West, years before he could induce any one to enable him boldly to launch forth in its search. So if you look to the discovery of the circulation of the blood, you will find that Harvey's previous life had been one of toil in the dissecting-room and at the sick bed-side; that he was thirty-seven years old before he alluded to the right theory of the circulation, and fifty when his great work on the motions of the heart and blood was published, having been previously fifteen years a lecturer on anatomy and surgery in the College of Physicians of London.

Jenner was just fifty when he first published the power of vaccination to the world. For years before it had been his daily thought; numerous varied experiments, made with the greatest caution and accuracy, had at length led him to certainty, but not accident. Numbers of medical men in his own neighbourhood had seen the effects of the vaccine pustule on the hands of the milkers, and had heard the popular notion of its being a defence against the frightful pest, small-pox; nay, Jenner himself had tried to interest them to make experiments on the subject, but in vain. Their minds were not adapted to such investigations; his mind was. While a boy, he had been a lover of natural history. He was a favourite pupil of John Hunter, imbued with the precepts and example of that great man to accept nothing as a fact till tested by rigorous experiment and the most cautious deduction. With such natural disposition, and a mind so schooled, he approached the investigation of the facts which led to his great discovery.

If we turn to John Hunter himself, we find that he was fifty-seven years old when he discovered the importance of tying the femoral artery high up in popliteal aneurism. How many years had he passed in the most indefatigable labour before arriving at this eminently practical and valuable fact!

Percival Pott was forty-three before he published the first of that series of important innovations in surgical progress, which he continued from time to time till the last at seventy.

If the progress of discovery in the human mind is slow, and the steps leading to it only sure when guided by knowledge, it is curious to see how slow, in some instances, the improvement is received by our profession — how cautiously, how suspiciously the invention is turned over before it is adopted. Some of Hunter's opinions, which are now current among us as axioms, were in his own day treated as chimerical theories. Jenner's invention, so apparently self-evident a benefit to mankind, encountered the strongest opposition and perversion; you would have thought he had been the greatest enemy instead of the greatest benefactor to mankind.

Harvey was nearly ruined by his discovery of the circulation of the blood, being driven out of practice by the obloquy and abuse showered on him by the physicians of the day.

The incessant wheel of habit wears so deep a track, that it becomes the most difficult thing to change it to a new one.

Perhaps no operation in surgery exemplifies the extreme slowness of improvement more strikingly than the capital one of amputation. For a long period no one dared remove a large limb; the means of arresting the bleeding were so imperfect that death was almost inevitable. At length it was found that in gangrene the ends of the arteries next the dead part were plugged up; in cases of mortified limbs, therefore, and in them only, was amputation performed, but through the dead part only, the living still no one ventured to cut. The efficacy of the actual cautery in stopping bleeding was next discovered, and amputation was undertaken, immediately after the incision the red-hot iron being freely applied to the wound. Now, Ambrose Paré says that this was a most dreadful and cruel proceeding. At the operation, the surgeon had a number of red-hot irons ready in a brazier to apply all over the fresh-bleeding wound, giving horrible torture, and such a shock to the patients, that they frequently sunk under this operation, at which no one can wonder, considering the large raw surface, its exquisite sensibility, and the large nerves. Besides, when the eschar made by the cautery fell off, it left a surface which frequently bled again, and required a second application of the iron; so that great loss of the end of the stump followed, with contraction and a protruding of the end of the bone, and exfoliation, and finally such a bad stump, that a wooden leg could hardly be borne. Four out of six died from amputation thus performed.

Purmanus, who practised in the seventeenth century, says, "This is a more terrible and dreadful operation than any in the whole art of chirurgery, for here a whole mortified and dead member must be cut off in the sound flesh, all the vessels, arteries, veins, nerves, ligaments, &c., must be first cut asunder with a knife, then follow the tormenting saw to tear the bone asunder, and sometimes burning irons to stop the bleeding, insomuch that some are pleased to call it an uncharitable, miserable, and cruel operation." To lessen the danger of bleeding and the pain of the operation, surgeons were led to the invention of instruments to remove the limb with the greatest rapidity. Purmanus says: "Mons. Paré, the French chirurgéon, has invented a machine, which by its great weight and sharpness cuts at once the skin, flesh, and bones asunder. Others, complying with the method of Botellus, fasten one knife under the member and the other above, and then with a sudden fall of a great weight cut the limb asunder. The first machine I ever saw used at Wesel, but without success, for it did not cut the leg through at once, but stopped in the bone, and was forced to be repeated, which made many shivers and splinters and an uneven bone. The second I saw done by Mr. Crause, a chirurgeon at Quedlinberg, on a countryman's leg, which, by reason of its greater weight, went somewhat better than the former machine, but the knives turned, the os tibiale was cut uneven and not quite through, and, therefore, he was forced at last to cut it right off with the knife and saw." How forcibly do these operations prove the justice of Bichat's observation, that about 200 years ago surgery was more a mechanical calling than an art.

Another precaution against the hemorrhage, as also to keep up the skin, which an assistant had previously pulled up as much as possible, a band or fillet was tied tightly round the limb a short distance above the place of incision. This had, of course, little or no effect on the deep-seated and really dangerous blood-vessels, it chiefly compressed the superficial veins, and hence congested the limb below it.

But still the bleeding after the incision had to be stopped by the application not only of the hot iron, but of various styptic balls, large flat pieces of agaric, and the like, irritating the surface of the stump and totally preventing union by the first intention.

At last Paré, about 250 years ago, hit on the only true and effectual mode of arresting the bleeding from the arteries of the stump, by putting a ligature on them. His method was as follows, and cannot but strike one as a wonderful advance on the previous plan; his directions are:—

1st. Pull up the skin and muscles, and tie a tight fillet round the limb to keep them up.

2nd. Make your incision with a curved razor or knife down to the bone.

3rd. Seize with a forceps the veins and arteries and tie them, no matter if a little muscle is included with them.

4th. Untie the fillet, and see if there is any more bleeding, then pass four ligatures through the lips of the wound, and tie them together so as to bring the lips of the wound in contact, but not too tightly or too much on the stretch.

5th. In case of secondary hæmorrhage open the wound, and with a needle and thread pass a ligature through the flesh round the artery and tie it.

Now, something was still wanting here, which was a means of so effectually securing the flow of blood through the main artery before making the first incision, that little blood should be lost when the incision was made. The garrot was the next attempt to accomplish this. But though the garrot was an improvement, inasmuch as it could be tightened without loss of time, and a compress fixed on the main artery, yet it was not a very secure contrivance, and required constant attention. Petit, 130 years since, invented the tourniquet, nearly exactly such as we use it at present, a vast improvement, in which security and easy management in controlling the supply of blood rendered the hitherto dreaded operation of amputation no longer one approached with anxiety on this account.

But obvious to us as is the advantage of the tourniquet of Petit, yet many still clung to the use of the old garrot—men of narrow minds, you will say; not at all; among the number was the eminent English surgeon, Mr. Sharpe, who, in 1761, forty years after, still recommends a fillet round the limb, the ends passing through two slits in a square piece of leather and tied over it, to be tightened by the old tourniquet, a piece of stick twisted under the knot, and over the leather which protects the skin.

Of the two great improvements, therefore, the ligature of Paré, and the tourniquet of Petit, we see that the last was reluctantly received; let us now turn to Paré's invention, and see whether it was more fortunate. Not a whit: directly his method was published to the world it was received with violent opposition, and, as so often happens, personal invective was used as freely as argument. One of his antagonists protests against the use of the ligature in the following terms:—He has acted badly, arrogantly, unadvisedly, and rashly who has dared to condemn the burning of the vessels, so much recommended and approved by all the ancients, desiring to teach a certain new mode of tying the vessels, against all the ancient physicians, and without reason, experience, and judgment, not regarding the much greater dangers arising from the ligature itself of the vessels (which he wishes to accomplish by plunging a sharp needle into the flesh) than from the burning. For if any nervous part, or the nerve itself, should be wounded, while by this new and hitherto unused method he absurdly tries to constringe the vessel, a new inflammation necessarily arises, and from it convulsions, and from convulsions death. Add to which the forceps with which, after the incision, he lacerates the flesh when he thinks to draw down the vessels that had retracted to their origin, do not give less pain than the application of the hot irons. If any one should survive safe after such laceration, he ought to return God thanks, through whose beneficence he escaped from such cruel flesh-tearing." Such was the language, such the kind of objections with which this invaluable discovery of this great surgeon was first met. It is scarcely to be wondered at, therefore, that its adoption was slow. Paré, very properly, only answered by a reference to facts, adducing a number of cases where the ligature of the vessels had been attended with the most complete success.

It has been fairly objected to Petit's tourniquet, that it has the same disadvantage that the first fillet used to compress the vessels, viz., that by its uniform circular compression it produces venous congestion of the limb below it. Some surgeons, chiefly of the Edinburgh school, have, therefore, rejected it, preferring to have the femoral artery compressed by the hand of an assistant during the operation. Our ingenious fellow-townsman, Mr. Read, cutler, of Parliament-street, has just invented a tourniquet free from this objection, the pressure being circumscribed to the artery, and a small part of the circumference of the limb. I shall certainly try it in the next amputation I am called on to perform.

I might still, continuing the subject of amputation, dwell on the very gradual improvements effected in the mode of incision; from the earliest way of cutting clear from the skin through all the structures straight down to the bone, which from the greater contraction of the skin and loose muscles than that of those fixed to the bone, always ended in a conical stump, to the method of Petit and Louis, who proposed a double incision, first through the loose muscles, and after their retraction, the second through the fixed muscles down to the bone, and subsequently, many years later, the still further improvement of Mr. Allanson, of Liverpool, who by carrying the edge of the knife upwards, making a pivot of the bone, round which the knife turned, contrived to make a hollow stump, at the bottom of which was the bone, which, when the wound was approximated, was necessarily completely covered.

The old curved knife was advantageously changed by Dessault for the straight knife at present in use; but I have dwelt long enough on this subject, which I selected to prove to you how slow, how gradual is the progress of any great improvement in our profession. How few discoveries start at once into perfection, and spring like Minerva from the brain of Jove completely armed.

The lesson to us from this brief history should be to endeavour to receive with a pure, unbiassed mind any rational novelty which is presented for our acceptance, not too credulous, not too sceptical, above all, not in a jealous, envious, cavilling spirit.

As I have said, discoveries are rarely matters of chance; with all the talent of invention the mind must be long previously schooled: before being discoverers you must for many a day have been careful observers, patient students; before adding to the facts already known you must have mastered a knowledge of those facts. This work must be begun now, here in this school, and in the hospital opposite must the foundation be laid. You will perhaps never again have the same opportunity of studying anatomy, and without you know anatomy well the practice of your profession, if you have any conscience at all, will be perfect misery. The course of a surgeon ignorant of anatomy will resemble that of a blind man, every step will be hesitating, uncertain, or leading to danger. Study it, therefore, now—in after life, engaged in professional duties, where will you find time?—in the country where will you find means?

As far as my observation goes, students may be classed under three heads:—

1st. Those entering the profession.

Like early travellers just starting on a journey through a strange country, the way still untravelled, still unknown, looks fair and inviting; in the distance the rugged steeps appear softened by a golden mist, the lofty tops on which they hope to take up a proud position stand out clear and distinct, the rough way is unthought of or overlooked. Fresh and untired, athirst for novelty, they are full of ardour for the journey.

2nd. The student in mid-career.

The novelty is gone—the labour has begun—and the real kind of work he has to do is plain; lectures on dry subjects are tiresome enough; dissection is repulsive, too many of the cases in hospitals are disgusting. Who would not avoid the distressing sights and sad scenes there? Here many stop, look back, and break down; some fairly cowed, and wanting resolution to face the work; others luring themselves into present idleness by the fatal self-deception that they have still plenty of time — that they can easily pull up their anatomy and surgery the last year.

3rd. The last year's student.

If he has worked steadily up to this time, he fears nothing. He has acquired a comprehensive acquaintance with surgery, and a good knowledge of anatomy; perhaps even the younger students look up to him as an authority. His labour is light, for it has become a habit. But let me turn to the last year's man, that has not worked — that has neglected lectures and dissections — that has walked the hospital, it may be, but observed little, and studied none. His final examination is at hand; the day seems approaching with fearful rapidity, when his lack of information will be no mystery; rejection even may send him disgraced home to his disappointed friends — friends, perhaps, who have imposed on themselves self-sacrifices to give him a profession, and whose fond pride and hopes his idleness has dashed in pieces to the ground. This too painful termination must be avoided; labour alone will do it; but what an amount of labour to make up in a short time for lost and neglected opportunities! An hour a-day with his grinder will not do; he must have two. Everything is sacrificed to preparation for the examination. Attendance at the hospital he thinks waste time; surgical books are merely read with a view to answer the examiners; on the same principle he applies rather to the Dublin Dissector than the dead body for his anatomy. Knowledge so hastily got from books, not things, is evanescent; it is not part of the man, as knowledge acquired by careful study and observation of the reality; it has no endurance, and soon falls from him, like plaister from a wall, showing the lath and rubbish beneath. A young man so crammed with examination knowledge may get his degree, and then enters the world a candidate for its favour; favour, let him expect none, but hard criticism on his actions, and severe judgment for his shortcomings. Does any young surgeon, a candidate for private practice, ask my advice, I would say, shun mere favour — put no trust in it; rely on no unmerited patronage — it is a short-lived bubble; trust alone to your professional knowledge and your upright conduct, and there will be no fear of success, of enduring patronage, and deserved favour; it may be slow in coming—in large cities very slow—but it will be sure.

In the hospitals of this great city, which you are about to attend, you will find the physicians and surgeons, with some exceptions, are men who have worked their way up to the high position they hold. Familiar with all forms and varieties of human malady, they will be your guides in the right observation of disease, and the best means for reducing deformity, relieving pain, remedying accident, and saving life. Let not their example be lost on you.

If you observe closely those whose professional success is the greatest, you will perceive that this success is not the result of accident, nor of what is commonly called "luck;" that they are not only men of ability, but that their natural gifts have been improved and strengthened by habits of unwearied application. It is in their studies that you will see the early lamp in the dark winter morning; it is on their labours that the first beams of the summer sun shine.

Men of self-denial—temperate in all things—when others give way to social indulgences, they pass the untasted wine-cup by.

Do you wish to occupy the position they hold —respected, looked up to, justly influential, with reputations widely extended, honoured abroad as at home—you must lay the foundation now.

If, again, you inquire into the career of those great men in our profession whose names glitter like stars in the darkness of the past, you will find their way to fame and fortune was the same. Bichat says of Dessault:—" At that age when the mind is shut against reflection, and only seems to open to pleasure, his first desire was to learn, his first enjoyment to know, his first passion to excel others. Nearly the whole day was spent in the dissecting-room, meditating on the remains of death skilfully displayed, or on the whole structure so wisely combined together in life. The moments snatched from his favourite studies were passed with the sick, or in pathological researches.

Ambrose Paré states, as the origin of his future great eminence and success:—"I resided three years in the Hotel Dieu, where I had the means of observing many surgical facts in an infinite number of sick people, as well as studying anatomy on a great many dead bodies."

Boerhaave, who was the most celebrated physician of his day—patients flocking to Leyden to consult him from all parts of Europe — was in his study every morning at four in summer, and five in winter.

The biographer of Dr. William Hunter says, his manner of living was extremely simple, he was an early riser, and when business was over, was constantly engaged in his anatomical pursuits, or in his museum.

John Hunter worked for ten years on human anatomy. Every morning from sunrise to 8 o'clock he dedicated his time to anatomical pursuits. Sir Astley Cooper says of him:—"Mr. Hunter was, as Lavater said, a man who thought for himself, but he was more; he was the most industrious man that ever lived. He worked from 6 in the morning till 12 o'clock at night, and sometimes later.

Let us see how Sir Astley Cooper himself reached that eminent position he so long and deservedly held:—

"For three years," he says, "after my apprenticeship expired, I did not seek business, but devoted myself to the study of my profession, and to teaching the students entirely. My industry at this time may be gathered from the following circumstances: I went to the hospital before breakfast to dissect for lecture. I demonstrated to the students before lecture. I injected their subjects. I lectured from 2 o'clock till half-past 3 on anatomy. In the evening, three times per week, I lectured on surgery. I attended to the interesting cases in the hospital, making notes of them, and in this latter practice I always persevered."

But I will not tire you by multiplying examples. Enough has been said to show you that success in your profession cannot be attained without labour and self-denial, and that those physicians and surgeons who attained fame and fortune in their own day, and whose names still live among the benefactors of mankind, owed their eminent positions to their having spent day after day in the dissecting room and the hospital. Let me pray you to remember this, and though, in following their estimable example, you cannot all hope to reach the high point they attained, still the most moderate talents, with upright conduct, may hope to secure, by persevering labour, a respectable and independent position. Certainly no time is more favourable to young men entering the profession than the present. The army, the navy, the East India Company's service are all competing for well educated surgeons. The last invite industry and talent by selecting their medical officers according to merit tested by examination. The demands of these services have relieved the overloaded ranks of the profession, and lessened the severity of competition for private practice. Whether, therefore, the ultimate object of the student be the public service or private practice at home, the chances of a certain provision for life are materially increased. The late Mr. Carmichael presents a remarkable instance of the rewards our profession offers to industry and talent. He very early worked his way up to a distinguished reputation, immediately followed by a large share of public patronage, which he ever after continued to enjoy. The large fortune which he thus acquired enabled him to secure, after death, a continuance of those benevolent exertions for the good of his profession which had been his cherished object during his life. Among other munificent bequests, he left to this school, which bears his honoured name, £8000, to be employed after a certain interval in erecting a new and more suitable building, and £2,000, the interest of which is to be divided in premiums for the several branches of the medical course. He well knew that in the breast of youth exist the noble spirit of emulation, the generous love of distinction; to minister to these, the Carmichael premiums were founded. The holder of one of these prizes has good reason to be proud; he will carry with him a proof of industry, talent, and superior knowledge, a testimonial of the most valuable kind, and years after, when the industrious student has become the distinguished surgeon, and the substantial rewards of public favour are his, he will still look back with pleasure to the day when, after a hard and honourable contest in this room, he received the first acknowledgement of superior merit.

Case of extensive Arachnitis complicated with Otorrhœa, the Result of slight Injury of the Head; Death in one Month from the Receipt of the Injury.

BY S. WILMOT, ESQ.,

SURGEON TO STEEVENS' HOSPITAL, LECTURER ON SURGERY IN THE CARMICHAEL SCHOOL.

Reported by Mr. George Farrell.

Francis Muldoon, a constabulary policeman, of adult age, was admitted into Steevens' Hospital, under the care of Mr. Wilmot, on the 10th September, 1855.

It appears that, on the day previously, he was seized with a fit, in which he fell, striking the left side of his head against a stone wall. He complained only of slight sickness of stomach and constipation of the bowels; and stated that he was perfectly free from pain in the head or elsewhere.

Sept. 16th.—Up to this date no tangible symptom was manifested; now the patient complains of pain in his head and stiffness of the neck, which he holds slightly curved backwards, and is unable to bend forwards. There is not, however, any rigidity of the cervical muscles; nor tenderness on pressure along the vertebræ. Neither can examination detect the least mark of injury about the cranium, either at the place which had been struck in the fall or elsewhere. The pulse is slightly accelerated; skin hot and dry; tongue loaded with a white fur.

Sept. 22nd.—The stiffness of neck continues, and the retraction of the head is greater; there is more fever, but the pain in the head is somewhat diminished.

Sept. 28th.—This morning the patient had a slight rigor, but no other change has taken place since last report, with the exception of a small amount of purulent discharge from the left ear.

Oct. 1st.—The symptoms have now become very urgent: the fever is high, and there is delirium at night; pain is not much complained of in the head, but the neck is thrown back to the full extent, and there is some tenderness on pressure over the left ear. The pupils are sluggish, but not dilated.

Oct. 9th.—The patient has continued much in the same condition for the last week. The delirium at night persists, and in the day-time he lies in a half drowsy state, and when spoken to and roused his answers are not clear and direct, though they cannot be considered incoherent.

Oct. 10th.—Profound coma has set in; fæces and urine are passed involuntarily; the pulse is rapid and feeble; the surface of the body is gradually becoming cold, and he is unable to swallow; about a thimble-full of healthy-looking pus was pressed from the left ear. He gradually sank, and died at 10 o'clock, P.M.

It is to be observed, that during the last few days of his existence the patient had slight convulsions on a few occasions.

Treatment. This mainly consisted in cupping, leeching, blistering, and the administration of mercury by the mouth and by inunction.

Autopsy, twelve Hours after Death.—There was no abnormal appearance in any part of the scalp. At the posterior inferior angle of the left parietal bone, the pericranium, for the space of about half a crown, was easily detached from the bone; and the latter was, at this spot, so vascular, that the blood transuded through the outer table. On removing the calvarium, the sinuses were found engorged with blood; the brain was everywhere highly vascular and congested, and felt firmer than natural; over the hemispheres were the evidences of extensive arachnitis; on the under surface of the brain, immediately in front of the pons varolii, a considerable collection of pus was found occupying the middle subarachnoid space; the surface of the pons itself was covered with soft lymph, and its substance, to a slight depth, was partially disintegrated; this condition extended to the parts within, and to a short distance around the circle of Willis; lymph was also effused beneath the arachnoid membrane of the upper part of the medulla oblongata, but the spinal chord was free from any traces of arachnitis.

It is to be regretted that no examination of the internal ear on the left side could be made, owing to want of time; no disease, however, could be discovered on superficial inspection, either of the mastoid or superficial portions.

Observations. This case demands but few remarks. It is obvious that the symptoms, which were so unequivocally marked, and so well explained by the *post-mortem* appearances, were referrible to inflammation of the arachnoid membrane, the chief intensity of which was exhibited at the base of the brain. The fixedness of the neck in a backward curve is an unerring sign of mischief (particularly inflammatory) at the base of the brain; but the absence of rigidity of the cervical muscles, observed in this case, is unusual, since they are often found as firmly contracted as in tetanus. Some might possibly be led to view this case as one in which otorrhœa was the primary affection, or as one of idiopathic arachnitis, the fit having been its first indication; seeing, however, that the discharge from the ear did not occur for several days after the patient's admission into hospital, and that its appearance was coincident with the period when the urgent cerebral symptoms set in, and giving due weight to the history of the case, taken in connexion with some of the *post-mortem* appearances, the conclusion at which we must arrive is, that the blow on the cranium sustained by the fall, slight though it had been, was the exciting cause of all the mischief. If this view be correct, the case detailed will form an interesting addition to those remarkable and comparatively rare instances of extensive inflammation of the brain, or its membranes, resulting from very trivial injuries of the skull, which have been published from time to time.

Lipoma of the Nose.

BY C. DUIGAN. F.R.C.S.I., Mullingar.

In the month of November, 1853, Mr. W., aged 50, consulted me relative to a lipomatous growth which commenced on his nose about ten years before that date, with slight discoloration and thickening of the skin, which gradually extended, increasing until it occupied its then size and position.

It involved the integument, covering both alæ, extending upwards as far as the junction of the cartilage with the nasal bones, and hung down in the centre so far below the level of the upper lip, as to interfere most disagreeably with his eating. The tumour was trilobate, resembling a much exaggerated ace of clubs. The surface, of a deep purple colour, was rough and granular, not unlike the rind of a fresh lemon, and a number of superficial veins ramified on it. The septum was sound, he never experienced any pain in it, the principal inconveniences resulting from it were its weight, interference with his eating, and its hideous deformity. I recommended the removal of the growth, to which he consented. On the 23rd of November, 1853, assisted by my friends, Drs. Ferguson and Stokes, I operated on him, commencing above by an incision in the sound skin, and slowly and carefully dissecting the whole mass from the surface of the cartilages, but keeping as close to them as was consistent with the precautions necessary to avoid wounding them. This part of the operation was slow and tedious, owing to the intimate connexion between the cartilages and the lipomatous growth, and the necessity for the entire removal of the latter.

There was smart hæmorrhage during the operation, but although some vessels bled very freely when divided, none required a ligature, the bleeding being easily restrained by cold application and slight pressure.

In four weeks the whole surface had cicatrized under the use of simple dressing, and the occasional application of sulphate of copper to repress exuberant granulation.

October 25th, 1855 (nearly two years from the date of the operation), I have examined Mr. W.'s nose; there is not the slightest return of the disease, and at a few paces from him it is difficult to recognize any trace of the operation.

The perfect propriety and facility of removing lipomatous growths have long since been demonstrated, and the proper means for so doing fully laid down; but there is one point of the greatest importance in operating for this disease, on which I think sufficient stress has not been laid in any of the published cases which I have seen, viz., the necessity which exists for the complete and careful removal of every portion of diseased skin, with a view of preventing a return of the growth.

I think it necessary to impress this the more forcibly, because the only other case of lipoma which came under my notice occurred in a gentleman from whose nose a growth of this nature had been removed about three years before, by a distinguished London surgeon, and the disease had in that time acquired more than its original bulk.

In performing the operation I agree with Mr. Syme (*Monthly Journal Med. Science*, September, 1852) that the finger of the operator, placed in the nostril, is the best guide to avoid wounding the cartilage; an assistant can be of much use by grasping with a double hook any portion of the detached mass, and, by keeping it on the stretch, facilitate the dissection of the remainder.

Belfast Clinical and Pathological Society.

The third Session of this Society was inaugurated, on Saturday, Oct. 27, in the Library-room of the Medical Society, by an animated and eloquent address from the President, Dr. Malcolm, upon which occasion a very large and influential muster of members and others was present. The President, in his address, observed that the Society, although comparatively recent in its establishment, had already 107 members on its list, 50 of whom had been enrolled as original members; thus showing a success which was most gratifying and encouraging. He then made some apposite remarks as to the principles of the Society, which, amongst others, were, the cultivation of pathology, connected with clinical observations, with all therapeutic data included in the latter. It also had in view the study of rare and interesting cases occurring in hospital and general practice, together with new and special modes of medical treatment. Another feature was, the exhibition and examination of new instruments, of all kinds, in surgical and other operations. A distinguishing feature, too, he stated, of this Society, was, the encouraging of the freest discussion on the reading of papers, the advantages of which could not be over-estimated; and that the debates, hitherto, at the weekly meetings, had been conducted in the most gentlemanlike and sober manner, which he attributed, in no small measure, to the steadiness and other admirable qualifications of his eminent and excellent predecessor in office, Professor Ferguson. He said that every new fact in pathological anatomy was useful in a practical point of view; that, in this way, a noble aim was constantly kept before the Society, which was the advancing of the cause of the profession; that Nature was to be the guide; and that it was a wise step for individuals to band themselves together for the attainment of professional knowledge, and for the accumulation of case after case, the value of which would soon be seen, even by the most obtuse. He further pointedly observed, that the stated meetings of their Society tended to refresh the knowledge of the members, as "iron sharpeneth iron," and also to strengthen good feeling amongst them. He concluded this very excellent address, of which the foregoing is but the faintest outline, by remarking that, as the continued success of the Society depended mainly upon individual co-operation, so each member should feel himself conscientiously bound to advance its important interests and objects; and, further, that the senior members of the profession should make it a duty to attend the stated meetings, if not to derive, at least to supply information to their younger brethren. The address having terminated, the following candidates for membership were proposed for election, by ballot, at the next meeting, viz.:—Dr. Leathem, Ballymoney; Dr. Robert Herd, Dr. Forsythe, Dr. Fras. M'Minn, Dr. Sheal, Killyleagh; Dr. Murray, Ballymacarrett; Mr. Weir, Dromore; and Dr. Seaton Reid. Dr. M'Cormac then read a paper, on an anomalous case in practice, which having elicited remarks, from its unusual nature, from Drs. Ferguson, Pirrie, M'Mechan, &c., was postponed for further discussion at the next meeting of the Society. Dr. Ross, one of the Secretaries, next read a very interesting paper on "The best and safest Mode of administering Hydrocyanic Acid," which was well received, from its practical value; after which the meeting separated.

Hospital Reports.

RICHMOND HOSPITAL.

Ligature of the Brachial Artery for Traumatic Aneurism at the Bend of the Elbow.

The following are the more important circumstances connected with this case, as they have been furnished to us by Mr. Thornhill, resident pupil of the hospital:—

Peter Crelly, æt. 30, was admitted into the Richmond Hospital July 23rd, 1855, under the care of Dr. Hutton. It appeared that six weeks previously the patient had been bled in the arm by an unqualified practitioner. The next morning there occurred a gush of florid blood from the wound, which was arrested by a bandage. In nine days the hæmorrhage recurred; a firm bandage was again applied, beneath which a piece of cork was placed, and in a few days the wound was healed, a pulsating tumour, however, remaining at the bend of the elbow. On admission the tumour was the size of a large walnut, projecting from a somewhat swollen base; all the usual signs of aneurism existed. The treatment by compression was first adopted, and Carte's brachial compressor was applied. Pressure was maintained for three weeks, with some little remission, accidental or otherwise. At the end of this period all pulsation in the tumour had ceased; the compression was, however, maintained for two or three days, and then removed. The integuments on the most prominent part of the tumour seemed to be thin, and of a dark brownish red colour, and presented a sense of fluctuation. This part, however, was without pain or soreness. After three days more the pulsation returned in the tumour; compression was reapplied for about a week, when no improvement having taken place, but, on the contrary, the tumour having increased, and the patient being wearied and extremely desirous to undergo an operation, rather than submit longer to the treatment by compression, Dr. Hutton proceeded to tie the brachial artery at the seat of injury.

Operation, August 22nd.—A tourniquet having been placed round the centre of the arm, the sac was freely opened by a longitudinal incision about three inches in length, and a large quantity of soft, black, coagulated blood was turned out, with a very small portion of laminated fibrine, which was found at the bottom of the sac; there the artery was observed everywhere adherent to the posterior wall of the sac, and a probe could be passed into the opening originally made by the lancet. The artery, being detached to the necessary extent, was secured by ligature above and also beneath this opening, and all further hæmorrhage was restrained. The vein was not observed during the operation, and had no close connexion with the artery. The wound was dressed lightly from the bottom, and a roller applied: nothing unfavourable ensued. On the tenth day the ligatures came away, the wound healed by granulation, and the patient was discharged cured, on the 25th of September.

Dr. Hutton observed that this case was, no doubt, an exception to the cases curable by compression, which, however, were now so numerous, that it did not materially affect the general conclusion as to the eligibility of this plan of treatment. With regard to the particular operation selected, Dr. H. was of opinion that the condition of the integuments, thin and discoloured, together with the soft, half-fluid nature of the contents of the sac, and the circumstance of the aneurism being traumatic, and not the result of disease of the arterial coats, indicated this operation, rather than tying the artery above the sac. He mentioned also having seen a similar case some years ago, in which the surgeon, after having tied the brachial artery above the aneurismal sac, had afterwards, in consequence of sloughing of the tumour, and secondary hæmorrhage, to secure the artery immediately above and beneath the original wound of its coats. The condition of the tumour in the case above given, and more particularly the nature of its contents, which were nearly devoid of laminated fibrine, afford some explanation, perhaps, of the want of success of the treatment by compression.

STEEVENS' HOSPITAL.

Amputation at the Ankle-joint (Syme's Operation).

The patient who was made the subject of this operation was aged 28. He had laboured under scrofulous disease of the left ankle-joint for upwards of six years, by which his health became seriously impaired. He was remarkably pale and anæmic, and suffered from night-sweats, alternating with diarrhœa. The foot was firmly fixed in an extended position, and immediately in front of the joint was a prominence formed, apparently by the astragalus, which seemed to have been partially dislocated. There were several sinuses around the joint, and on the dorsum of the foot, which discharged copiously, and through which small portions of the bone had passed at different periods. Doubts were entertained of the propriety of Syme's operation in this case, owing to an apparent enlargement of the tibia immediately above the ankle-joint, and to œdema of the leg, which extended to the knee; it was finally determined, however, to comply with the patient's request, to leave him as long a limb as possible. The operation was performed in the manner usually adopted at present. An incision was made across the sole of the foot, in a straight line from the centre of the external malleolus to that of the internal; a semilunar one was next made across the anterior part of the ankle-joint, connecting the angles of the first incision. The joint, which was partially anchylosed, was now opened in front, and the tendo Achillis being divided, the skin of the heel was dissected from the os calcis, and the separation of the foot was effected. A saw was then applied to the extremity of the bone, and a thin plate of the tibia, with the two malleoli, was removed. The hollow flap of skin having been brought forward, it was retained *in situ* with the twisted suture and long strips of adhesive plaster. There were four circumstances which materially impeded the performance of this operation:—First, the ankle-joint was partially anchylosed, and the astragalus was, to a great extent, absorbed, what remained of it being thrown completely out of place, so that the proper guide to the eye was wanting. Secondly, the anterior row of tarsal bones were so much implicated in the disease, that they gave way at their points of articulation under the force exercised by the left hand, which is resorted to for the purpose of assisting in disarticulating, thus the purchase for the hand, which it was the more necessary to have, owing to the state of the joint, was wanting also. Thirdly, the skin and structures covering the os calcis were greatly thickened, and accordingly unyielding, so that it was difficult to reflect the flap. Fourthly, the os calcis itself was unusually enlarged. Notwithstanding these impediments an excellent stump was formed. In a fortnight after the operation, the line of incision was principally united, and the patient's health was remarkably improved. Two or three small abscesses formed at the back part, and at the anterior edge of the flap; still at the end of six weeks the patient was enabled to leave his bed and walk about on crutches.

It is now upwards of two months since the operation was performed. The patient can bear his full weight on the stump, but there are two small sinuses which are constantly opening and closing at each angle of the line of incision, and they prove a source of great annoyance.

Perineal Section; Syme's Operation somewhat modified, owing to the Length of the Stricture; Cure.

The patient on whom this operation was performed is a man of thirty-five years of age. The stricture was occasioned by a fall on the perineum, which produced rupture of the urethra, and he had laboured under the disease for nine years. Within the last three years he had been in hospital three or four times, under the care of Mr. Wilmot, who always succeeded in dilating the urethra by the persevering use of the conical catheter and gum-elastic bougie. Shortly after he left the hospital, however, the stricture invariably returned, and became as tight and unyielding as before. On the last occasion, the patient left the institution before the temporary cure of the stricture was completed, and owing to the manner in which he then neglected himself, his disease became greatly aggravated, partial infiltration of urine occurred, leading to abscesses, urinary fistulæ.

At the time of his last admission into hospital the stricture was so tight that it was impossible to pass the smallest flexible bougie through it, and the metallic instruments, which on former occasions could be introduced, were stopped by an obstinate resistance close to the neck of the bladder, after they were by persevering efforts passed through the anterior obstruction. The perineum was quite contracted, and as hard nearly as cartilage, and in it, as well as on the scrotum, were several fistulæ. The patient's health was much impaired. The urine was normal in its character. Several attempts were made to dilate the stricture fully, but they were utterly fruitless.

It was now determined to lay the perineum freely open, which was considered necessary, from the contracted state of the canal, and to perform Syme's operation as far as it was practicable. The patient having been placed in the proper position on the operation table, the staff employed by Mr. Syme was with some difficulty passed into the bladder, and the steps of the operation, as laid down by that surgeon, were regularly gone through, the urethra being fairly laid open opposite to the perineum. On removing the staff, however, it was found impossible to introduce any other sort of instrument, for the stricture extended so far forwards, as to reach nearly to the root of the penis, and the incision could not have been prolonged so as to divide it without going through the scrotum, and thus making a wound of an unwarrantable length. There were but two methods to be adopted; one to make a second incision, commencing it at the root of the penis, and thus to divide the anterior part of the stricture; the other to pass a gum-elastic catheter into the bladder, through the incision in the perineum, and retain it there, and to endeavour afterwards to cure the anterior part of the stricture on the ordinary principle of absorption. The latter plan was pursued, and it proved perfectly successful. After the urine had been escaping for some days through the opening in the perineum, and that thus the urethra was left in a perfectly quiescent state, a conical silver catheter, of No. 4 size, was passed along the canal into the bladder. The cure of the stricture was not as rapid as it otherwise would have been, in consequence of the patient's inability to retain a metallic instrument in the bladder, for more than a few hours, and at this period no other kind of catheter could be introduced. However, after a little time, a No. 6 metallic catheter was passed, and this instrument the patient was enabled to wear in the bladder for 24 hours. When it was withdrawn, a gum-elastic catheter of same size was introduced with ease, and its presence in the bladder gave rise to no inconvenience. The stricture now rapidly yielded, as the size of the gum-elastic instrument was increased, and the fistulæ are already nearly closed. How far the plan adopted here proves of permanent benefit has yet to be told, and will in due time be communicated.

MERCER'S HOSPITAL.

Case of Phagedenic Ulceration of the Groin, attended with high constitutional Disturbance, and caused by the undue Administration of Calomel.

Reported by Mr. Hugh Croskery, *Resident Pupil.*

The following case presents a good example of what was at one time a very common occurrence in the Dublin hospitals, a simple sore converted into a phagedenic or sloughing ulcer, by the injudicious or excessive use of mercury. Such cases have now, happily, almost entirely disappeared; but we sometimes, as appears to have been the case in the present instance, meet with individuals of that peculiar diathesis that a very small quantity of mercury is sufficient to induce peculiar unhealthy and destructive local action, or even to bring on violent erethismus.

J. W., aged 27, was admitted into Mercer's Hospital, September 20th, 1855, under the care of Mr. Tagert, with a large sloughing phagedenic ulcer in the groin, five inches long by four broad, and at least half an inch in depth. The patient is a young man of temperate habits, and, up to this attack, was healthy, and never had syphilis before. About four weeks since, he contracted a chancre on the glans penis, which, being neglected, spread to the prepuce. In the course of a fortnight a gland in the groin began to swell, and having gone on to suppuration, was opened on the 9th of September, when a good deal of pus was evacuated. He was now ordered calomel and opium, and the wound poulticed with linseed meal. In a few days it assumed a phagedenic character, and rapidly increased in size. The mercury was now given up, and the ulcer brushed with nit. argent. It continued to spread until he was admitted into hospital. The surface of the sore was then of a dark ashy colour, and the edges presented an irregular jagged appearance. Several large sloughs also were being detached. The smell was so fetid that one could scarcely approach the bed. The patient was labouring under high symptomatic fever; the pulse quick, but not strong in volume; the tongue loaded, and the countenance betrayed great anxiety. A linseed poultice, sprinkled with chloride of soda solution, was immediately applied, and some mild aperient medicine administered.

Sep. 21st.—A few sloughs were removed this morning, and the entire surface brushed with strong nitric acid, which application gave the patient a great deal of pain. Immediately after applying the acid, a piece of lint, wet with an alkaline lotion, was laid over the sore; and from this the patient expressed great relief. To have an opiate draught immediately, and a grain of powdered opium three times a day, washed down with sulphatis quininæ, gr. iij., aquæ distillat. ℥j., acidi sulph. dil. m. x.; to have also a pint of porter and a pint of beef tea every day.

The prepuce is nearly gone, but the ulceration here appears to be stopped. To be touched with nit. argent, and black wash constantly applied.

Sep. 22nd.—Had some sleep last night; Sore not half so painful; several sloughs were easily removed. To be dressed with pledgets of lint, dipped in oil of turpentine.

Pulv. opii et mistura quininæ continuantur ut pridie. Diet as before.

Sep. 23rd.—Healthy granulations now appear where the sloughs came off on yesterday, and the ulcerative process seems to have been altogether arrested. The febrile irritation, also, which the man was labouring under when admitted into hospital, has subsided. The granulations to be dressed with lotio nigra.

24th.—The sloughs have all come off, and the surface is granulating healthily.

Oct. 3rd.—The sore is now not more than half the size it was; the ulcer on the prepuce has healed.

11th.—For the last eight days the patient has been up, and about the garden attached to the hospital; his appetite is good, and he feels strong as ever he did. The healing has progressed rapidly and steadily, and the granulations are now on a level with the surface. The patient left the hospital to-day, without permission; cured, however, of the disease for which he was admitted.

The beneficial results accruing from free cauterization, in cases of phagedenic ulceration, the constitution, at the same time, being kept up by tonics, good nourishing diet, &c., were well shown in the above case. The quantity of calomel given was very small, and yet the destruction of parts which ensued, in so short a time, was rapid and most extensive.

Bibliography.

Statistics and Treatment of Typhus and Typhoid Fever, from twelve Years' Experience gained at the Seraphim Hospital, in Stockholm (1840-1852). By MAGNUS HUSS, M.D., Professor of Clinical Medicine in the Caroline Institute, &c. Translated from the original Swedish, by ERNEST ABERG, M.D., pp. 200. London, 1855.

We have seldom had so much reason to regret our want of space as in our endeavour to give a suitable notice of the above work. A practical work on fever is, perhaps, of all others, that most calculated to attract the attention of medical readers in Ireland, where typhus fever is always more or less prevalent.

Gladly would we discuss with the author, did space allow us, the absorbing question of the day as to the identity or non-identity of typhus and typhoid fevers. They are termed by him typhus petechialis and typhus abdominalis, and are considered to be "not two distinct morbid processes, but varieties of the same." Our author, however, writes from cases which he has actually seen; and accordingly, in another place, we find him recording his experience, "that the extreme links of the typhus chain, the severer cases of typhus petechialis, and the clearly marked ones of typhus abdominalis, are easily distinguished by the absence in the former, and presence in the latter, of symptoms referrible to the intestinal tube; but that a number of forms between the two extremes occur in which this distinction by no means holds good." When, however, the extreme cases are so very easily recognized, it is more than probable that there must be a great many more also sufficiently easy of diagnosis before we come to those where much difficulty exists. And is not this, after all, the most that is insisted on by those who hold the non-identity of the two diseases? and is it not what daily occurs in our diagnosis of the exanthematic diseases? The ordinary cases of scarlatina and measles are sufficiently distinct; but who has not seen cases where, for a time at least, the diagnosis was more or less obscure? We know that these two diseases were for a long time believed to be identical.

We reluctantly pass over the first two chapters, which contain a great amount of well arranged, valuable information on the symptomatology of typhus, and also several useful statistical tables, and hasten to the subject of treatment, to which the author has devoted more than half the work.

From the first section of this chapter, *on the nature of typhus*, we copy the following paragraphs, "from which summary exposition of the nature of the typhus process, the author's views with regard to its treatment are easily deduced."

1. *The primitive cause of the typhus process seems to be a peculiar change in the blood. The chemical characters of this change are—diminished proportion of fibrine, and increased proportion of several inorganic salts, especially carbonate of soda.*

2. *The typhus process, once fairly established within the system, must pass through its given periods; no treatment has as yet been discovered by which it can be shortened.*

Treatment is considered according to the three different stages of premonition, irritation, and depression—the first by no means the most unimportant. In no disease is so much malpractice daily observable as in the treatment of the premonitory stage of typhus. This is the more grievous, because it is, in most cases, irremediable. While we write, we can point to three different cases, where, from heroic practice of different kinds, in the early stages of typhus, three valuable lives are being sacrificed. "In accordance with the above stated opinion, that the typhus process is not by any means to be cut short, it follows that our endeavours at treatment of the premonitory stage can only be intended to answer the question, whether there is any treatment of this stage, by which we may succeed in mitigating the symptoms of the subsequent stages, and thus give the disease a milder, and consequently a less dangerous nature?" The author replies, that his experience is not extensive enough to give a decided and satisfactory answer to this question. We may collect, however, what that experience was, from the effects of the medicinal remedies adopted.

1. *Hippo Emetics.*—"In most cases the irritative symptoms of the first stage became milder afterwards than where, under the same conditions, no emetic was given." He enumerates the indications and contra-indications for their administration. The latter greatly preponderate; and he ends by saying, "I have many times observed that, when seemingly indicated, they have proved to be ineffectual, and the decision difficult whether their administration was beneficial or not."

2. *Cathartics.*—"Experience tells me that purges of all kinds can most commonly do harm, and only be of service exceptionally."

3. *Bloodletting.*—"General bleeding I consider decidedly injurious. It may diminish the symptoms of irritation, but increases the depression, and retards convalescence." He adds, "I have seen, not so seldom, patients who have been bled during the prodrom stage either die or have the stage of depression unusually severe, and the convalescence uncommonly protracted." The symptoms from the brain were often milder during the following stage, from the application of two or three cupping-glasses to the back of the neck, in cases of marked signs of congestion to the head.

The treatment of the stage of irritation is considered under the following different heads:—1. Evacuantia; 2. Derivantia; 3. Mineral acids; 4. Treatment of special symptoms; 5. Dietetic and hygienic rules.

The *evacuantia* are not more strongly recommended in this than in the former stage. The contra-indications for *emetics* still prevail. We read that "in most cases this remedy has appeared to me to be injurious;" and, when wrongly administered, "the strength sinks, the state of irritation in the mucous membrane of the stomach and the intestinal tube is increased, and the general state becomes much worse." *He* adds, "The use of emetics, after the third day, I consider almost always detrimental." With regard to—

Cathartics.—"The so-termed purgative method I have tried, but found no favourable results."

The remarks on *blood-letting* are peculiarly deserving of consideration. "My experience entirely condemns the use of general bleeding. I have given it a fair trial, when there was a strong determination to the brain, with marks of impending exsudation, and violent delirium, as in capillary bronchitis and congestion to the substance of the lungs, but have never seen the effect correspond to my expectations. On the contrary, the strength of the patient sinks rapidly after the use of the lancet, the tendency to exsudation from the membranes of the brain, or to paralysis of the brain, seems to increase rather than diminish; the congestion to the bronchi and lungs is lessened immediately after the bleeding, but soon returns, often in a severer form. Topical bleedings are, on the other hand, oftener indicated, and prove useful and beneficial." He prefers cupping to leeching, and goes on to detail the cases in which topical bleeding is indicated; we cannot agree in one rule which he lays down, viz., *that it must not be employed after the fifth day at latest.* There is not a single day in the whole course of fever, in which circumstances may not render advisable the local detraction of blood, which, if judiciously managed, *will* "act against the system for which it was intended, *without* causing prostration of strength." We would also differ from our author in preferring, in the majority of cases, leeches to the cupping glasses, particularly if the application is to be made to either the head or abdomen.

The *Derivantia* consist in—1. *Application of ice to the head; 2. Mustard poultices, or hot embrocations of turpentine; 3. Blisters; 4. Heating cold water compresses.*

The practical remarks made on each of those applications are well worthy of perusal. The general use of blisters is strongly deprecated. "Wherever employed as a rule they are to be condemned. A blister applied at a wrong time to the neck does harm by disturbing the patient, increasing the delirium and pain, and has, besides, a great inclination to slough." He considers blisters advisable if the case seems to be passing into cerebral effusion. While we disapprove of all general rules in the treatment of fever, we must confess that the use of blisters is, perhaps, too indiscriminate; and the great value of this chapter on treatment consists not so much in the medical treatment which the author recommends, as in the mal-practices and interferences which he warns us against. A most convenient modification of the water compresses which the author so strongly advises, will be found in the constant use of well-wetted spongio-piline. We have derived the greatest advantage from it in cases of great intestinal irritation.

From the extracts which we have made, our readers may form some notion of the truly practical nature of the work. The remainder of the chapter is equally worthy of perusal. It contains the author's experience as to the use of different internal remedies in the treatment of fever—of its complications—and of its sequelæ—interspersed with many practical remarks. We conclude with the following very valuable extract:—"Many methods have been lately proposed of treating typhus fever. From these experiments I have, however, learned much, and come to the conviction, that there is no therapeutic method exclusively applicable to typhus, but that we must arrange our indications in accordance with the most prominent of the symptoms, and that in the choice of our remedies we are as often obliged to relinquish the strict method, as we are able to follow it. Eclecticism is, therefore, the only way, according to my experience, that we can or ought to follow."

The work is that of a truly practical physician, and may be read and studied with advantage, by both student and practitioner.

Traité des Fractures et des Luxations. Par J. F. Malgaigne, Professeur de Medecine Opératoire a la Faculté de Mèdecine de Paris; Chirurgien de l'Hôpital Saint-Louis; Officier de la Legion d'Honneur, &c. 2 vols., with an Atlas of Plates.

(*Continued from page* 300.)

3. *Subglenoid Dislocation.*—This form of luxation was first observed by Petit, but the term subglenoid was given to it by Goyrand, who saw but three examples of it. Malgaigne has been able to ascertain the history of about twelve cases only. Mâlle gives the dissections of five cases* in which the dislocation was artificially produced.

Its *causes* would seem to be the same as those of the complete subcoracoid luxation, most frequently a fall on the arm when it is separated from the side, or occasionally forcible elevation of the arm alone. Goyrand has seen it produced in a person who, having fallen, was hastily lifted up by the arm by another who was accidentally passing by. As to the causes which influence the occurrence of different forms of displacement, Malgaigne observes:—"When the arm is forcibly elevated, we have seen that the head of the humerus is directed downwards and forwards, but the posterior and upper portion of the capsule being uninjured, it is prevented from going any further, and then, when the arm falls by its own weight, the anterior and inferior part of the capsule being extensively torn, allows the free escape of the head of the humerus, which mounts up beneath the coracoid process. Again, if excessive violence is used, the head of the bone may be driven *in any direction*, according to the direction of the force, and may pass downwards and backwards between the muscles, downwards and forwards through the integuments, or may even be driven inwards through the side of the chest, of which Prochaska has preserved a remarkable specimen in his museum, On the other hand, if by slight violence the capsule is torn inferiorly, leaving its anterior portion uninjured, this portion, when the arm falls by its own weight, prevents the head from ascending up close beneath the coracoid process (as in the preceding dislocations), and in reality this was the obstacle found in five instances by Malle.†

The symptoms which may be regarded as *characteristic* of this luxation are—1st. Excessive abduction of the elbow. 2nd. Unusual elongation of the arm. 3rd. Extreme tension of the deltoid over the empty glenoid cavity. Robert has seen the arm form with the side an angle of more than forty-five degrees. In one case Malgaigne found the arm to form a right angle with the body. Four dissections of this luxation are given.

Pinel gives a case which was complicated with fracture of the humerus. The head of the bone lay half an inch below the point of the coracoid process, and had formed a small surface on the lower part of the internal glenoid edge. The preparation is in Dupuytren's museum (No. 721).

Sir A. Cooper dissected the shoulder of a sailor, who fell from a height, and was killed almost immediately. The head of the humerus was thrown on the inferior edge of the scapula, between it and the ribs; the axis of its new position was an inch and a-half below that of the glenoid cavity. The capsule was torn from all the internal edge of the glenoid cavity, the tendon of the subscapular muscle was extensively torn. The distance between the head of the humerus and the coracoid process is the only pathognomonic sign of this luxation.

The *prognosis* and *treatment* are the same as for the ordinary subcoracoid luxation.

The reduction is never difficult. Vertical and horizontal extension, as also the method by the knee, have all succeeded in different cases; in one case, the patient being under the influence of chloroform, the bone slipped in whilst it was being examined. In luxations of long standing, the reduction, of course, may be impossible.

4. *Dislocation internal to the Coracoid Process*—(*Intrà Coracoïdienne*).—In the luxation thus named by Malgaigne, the head of the bone, instead of lying beneath the coracoid process, passes internal to it by two-thirds or three-fourths of its diameter; it has generally been confounded with the ordinary luxation into the axilla.

This is the most common of all the luxations of the humerus; of forty-nine cases of Malgaigne's, more than two-thirds were of this variety. Since 1841 this has been remarked by Velpeau.

In the great majority of cases, its cause is a fall on the shoulder, or a blow directed against it. Twice only has Malgaigne seen an exception to this: in one of them it was caused by a fall on the hand, in the other it was occasioned by a person in jest giving another a blow with the hand, the arm being extended.

The symptoms are mainly those which are met with in the subcoracoid luxation. Thus there is prominence of the acromion, a hollow beneath it, abduction of the arm, limitation of all voluntary movements, whilst communicated motions are a little more free. But the abduction of the arm is very slight, generally four or five fingers' breadth; the upper end of the humerus is very remarkably inclined inwards, and externally a very remarkable hollow angle is seen at the insertion of the humerus. Another remarkable symptom is *rotation of the arm inwards*, the epitrochlea looks almost directly backwards. (In the subcoracoid luxation the arm is generally rotated outwards.) The length of the limb is very variable, the lengthening being generally but slight. The characteristic signs are to be sought for from the side of the axilla; when the position of the arm is not altered, the head of the humerus cannot be felt; but when the arm is drawn outwards, then the head descends, and can be felt; when the arm becomes horizontal, it lies close under the integuments as in the subcoracoid dislocation. Crepitation has been observed by Velpeau in some cases of this luxation. Malgaigne says that its cause is fracture of the great tuberosity, another sign of which is ecchymosis of the inner portion of the arm, which is sometimes excessive. Generally the detached tuberosity is drawn beneath the acromion, and can be felt there; but sometimes it remains united to the head by fibrous tissue, and then occupies the lower part of the glenoid cavity, where it forms a tumour which may lead to errors in diagnosis. The *pathology* of this accident is fully given, M. Malgaigne having made six dissections of it. In Case 1 the results were these:—The tuberosity was detached and broken into two fragments, these lay beneath the acromion; the capsule was vertically torn on its inner side; the head of the humerus lay *below* and *internal* to the coracoid process, covered by the subscapularis, having the coraco-brachialis and the biceps to its outer side; part of the articular surface lay against the inner surface of the neck of the scapula, separated from it by some lacerated fibres of the subscapularis. The anterior glenoid border lay in the groove between the head and the torn off tuberosity; the head of the bone internally corresponded to the second rib, with the intervention of the subscapularis.

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* Memoires de l'Acad. de Medecine, tom. viii. p. 595.

† Op. cit.

The tuberosity is found detached in the great majority of autopsies.

The *diagnosis* may be thus established. There is a depression beneath the acromion, and the head of the bone lies beneath the coracoid process, as in the former case, but cannot be felt in the axilla, whilst two-thirds or three-fourths of it lie internal to the coracoid process. In a recent case, the crepitation from the detachment of the tuberosity, the projection of the fragment towards the axilla, and the deceptive appearance of shortening may cause this accident to be mistaken for a fracture of the neck of the humerus. But in the fracture the depression externally is not so immediately below the acromion, the head of the bone cannot be felt internal to the coracoid process, and lastly, in the luxation, when the arm is abducted, the round head of the humerus becomes distinctly felt in the axilla.

In 1833 there was a great dispute on this subject between two eminent surgeons in London. A young girl, eleven years old, fell from the second story of a house on her right shoulder, and a month after the accident came under the care of Lynn (Newcastle?). There was flattening of the shoulder, whilst an irregular osseous tumour lay beneath the coracoid process, which followed the rotatory movements of the humerus. The glenoid cavity was occupied by another bony tumour, which likewise accompanied the rotatory movements of the arm, whilst the finger could distinguish a vertical depression between them. Lynn diagnosed a separation of the epiphysis, with displacement forwards of the shaft, which had united at a considerable angle with the upper epiphysis, which latter remained "in situ." Guthrie, on the contrary, supposed that a longitudinal fracture of the humerus had taken place, running down in the direction of the bicipital groove, and dividing the head into two unequal portions. In 1837, R. W. Smith met with an analogous case in the dead subject. Dissection showed him that the head of the humerus lay below and internal to the coracoid process, and that a fracture had detached the tuberosity only, which corresponded to the inner part of the glenoid cavity. In a word, he had before his eyes the true *intra-coracoid luxation*; yet such is the force of prejudice, that, when he met with an example of it in the living subject, he agreed with Adams, of Dublin, in the opinion that there was no luxation, but only a fracture of the great tuberosity.* As to treatment, Velpeau has the merit of distinguishing this luxation from all others. Vertical extension, he says, is best adapted for the subcoracoid luxation (subpectoral, *Velpeau*), and horizontal extension for the intra-coracoid (subscapular, *Velpeau*). Malgaigne agrees with this advice. In the latter case he would combine with horizontal extension, direct pressure or a to-and-fro motion (*la bascule*). After the reduction, in very many cases, a crepitus indicates the fracture of the tuberosity; this will be obtained by pressing up the arm, and producing rotation.

5. *Subclavicular Luxation.*—In this form the head of the bone is internal to the coracoid process, and approximated more or less closely to the clavicle. This luxation is extremely rare. It is this which should only be called the dislocation *forwards*. Scattered cases of it are recorded by White, Bromfield, Dupont, Hey, &c. Up to 1834, Malgaigne had only seen two examples of it, and since then had not seen more than five. Hence, it was by chance, he thinks, that Petit met with three cases in one month.

Symptoms.—There is the usual deformity of the shoulder, a prominent acromion, with a depression beneath it; besides, the arm is generally closely applied to the side, without being at all rotated. No matter how deeply the fingers are pressed into the axilla, nothing but the shaft of the humerus can be felt. Generally the prominence formed by the head of the humerus beneath the clavicle is very obvious, placed internal to the coracoid process.

This luxation is the most difficult to reduce of any.

In a dissection of this luxation by M'Namara, the head of the humerus had mounted up above the subscapularis, which formed a curve lower down, which corresponded to the front of the neck of the humerus; hence, the head of the bone was only covered by the deltoid and great pectoral. A greater degree of force had driven the head forwards between the muscles in one case observed by Malgaigne, so that only the integuments covered it. The capsule was largely torn above and in front, being uninjured below. Neither the muscles nor tendons were torn. In an old, unreduced luxation of this kind, dissected by Sir A. Cooper, the glenoid cavity was filled up, and the head of the humerus, which lay beneath the clavicle, close to the first rib, was received into a new socket with a complete border, which extended over about one-third of the extent of the subscapular fossa, and was surrounded by a complete new capsule. Cases illustrating the difficulty of reduction are alluded to; and, in conclusion, Malgaigne advises extension at first to be made downwards and outwards, until the head is got below the coracoid process, when horizontal extension may be employed. Key has succeeded by very gentle means, after forcible extension had failed.

6. *Supracoracoid Luxation.*—Once seen as the result of accident, and once as the result of disease.

Case.—A man of sixty-eight years of age was thrown with great violence on his shoulder by the upsetting of a cart which he was getting into. He suffered great pain, with inability to use the arm. A "bone setter" used violent extension. Two months and a half afterwards Malgaigne saw him; the head of the humerus was luxated *upwards* and *forwards* through the acromio-coracoid ligament, and corresponded externally to the acromion, and internally (partly) concealed the coracoid process, being limited above by the clavicle. The deltoid was much pushed forwards, and further in the head of the bone had separated the deltoid and pectoral muscles, and here came very near the surface. The arm was slightly shortened. Very forcible extension was used; it was thought, at last, something had been broken, but no fracture was discovered; after this the patient had more use of the arm. "I had an idea," says Malgaigne, "of dividing the acromio-coracoid ligament, which seemed to be an obstacle to the reduction, but, after grave reflection, I deemed it better to abstain."

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* R. W. Smith. Archiv. Gén. de Médecine. 1838. t. i. p. 184; and Treatise on Fractures, &c., p. 176.

Die Lehre vom Auswurf. Von Dr. Anton Biermer, Vormals Assistenzarzt der Medicin, Klinik am Juliusspitale zu Würzburg.

Having given, in the last Number of the Hospital Gazette, a compendium of Dr. Biermer's historical introduction on the subject of expectoration, we now proceed to lay before our readers an epitome of his work, which we look upon as a most valuable contribution to clinical medicine.

Dr. Biermer's opening chapter contains a definition of expectoration, some observations on its composition, and its semiotic value. The ingredients of the sputa have their origin in the respiratory apparatus, and are thus *essential* in a diagnostic point of view, or they are merely acquired *in transitu*, and are mere accidental formations, and consequently non-essential.

Examination of the sputa may be conducted by the unaided eye, or a microscopic or chemical scrutiny may be required. With reference to the latter, the constituent parts are divided into the morphological and organized, and the amorphous and unorganized. When the sputa, the result of the normal secretion of the mucous membrane, and that which is the consequence of local lesion, are placed together, we have then the physiological and pathological products. The distinction, however important, is, for the most part, very difficult, because the boundaries between the normal and pathological secretion cannot frequently be determined, or the distinguishing characters lie merely in the quantitative proportions of single constituents, not in any real difference in the elementary forms. An example is seen in the oft-debated distinction between mucous and purulent sputa, where the difference frequently consists in the greater or lesser amount of cells, and in some difficult to be discovered chemical attributes.

The value of an examination of the excreta may be estimated by reflecting that thus are brought to light the products of a number of hidden diseases. Take, for illustration, a case in which fragments of elastic lung-tissue are found in the sputa, and the other symptoms have not as yet determined the existence of a lesion of the organs of respiration; here we have a sign of much value, or in the early period of febrile disturbance, where, when owing to the absence of all objective and subjective signs of pulmonary disease, we cannot recognize its presence, a single characteristic sputum may possibly afford us evidence of commencing pneumonia.

Dr. Biermer fully recognizes the difficulty which the physician experiences in his attempts to determine from what particular part of the respiratory membrane the expectoration is derived. The anatomical identity of the mucous membrane, and the resemblance between the pathological products, render this generally unattainable, nevertheless the form and constitution of the sputa, and the subjective sensations may assist. The author agrees with Bühlman, that a knowledge of the source of the sputa can only be arrived at in most cases with probability, not with certainty. Admitting the absence of perfection on this point, the semiotic value of the sputa, in manifold cases, is beyond question.

As to the methods of investigating the sputa, they are three in number, and each redintegrates the other. 1st. the examination with the unassisted senses; 2ndly, the microscopical; and 3rdly, the chemical.

The first, which Dr. Biermer also denominates the makroscopical, with all its imperfection, has afforded most useful diagnostic information. We ascertain by this method the quantity, form, consistence, colour, transparency, specific gravity, taste, smell, the existence of air, mucus, blood, &c., &c. The expectoration should not be examined *en masse* in a spittoon, nor shaken up together. It should be inspected in small portions, and for this purpose it should be spread out, as Jul Vogel directs, on paper. In many cases it is better to pour the sputa into a glass with water; and when it is necessary to observe the form of single sputum, the patient should be directed to expectorate into a flat vessel of water.

The taste of the sputa, the feel as to the temperature, and the local sensation produced by the act of expectoration, should be noticed. Microscopic research teaches us the constitution of the morphological elementary parts of the sputa, and is of infinite value in diagnosis; it brings under our notice the cells and rudiments of cells, it enables us to judge of the quality of the morphological parts, and by their quantity enables us to form an approximative conclusion as to the proportion the cells bear to the amorphous parts of the secretion. We can determine the presence of blood and pus corpuscles and epithelium, and their quantity.

Dr. Biermer gives directions as to the manner of conducting the microscopic examination of the sputa, and states that the magnifying power which is best adapted for examining sputa is one of from 400 to 500 diameters. To the student of medicine who cannot consult the German writers who have done so much towards erecting histology into a science of practical utility, we recommend the work of Dr. Beale, "The Microscope in its application to Clinical Medicine."

Touching the clinical examination of the sputa, Dr. Biermer remarks that the belief in its inability to afford information which has been entertained by some—namely, Bühlman, Heinrich, Wunderlich, &c., is not well grounded, and he refers to the labours of Pearson, Brett, Simon, Vogel, Wright, and others, who have at least pointed out the path for future investigators to pursue, and which is likely to lead to valuable discoveries.

As an illustration of the highly important aids which diagnosis derives from chemical research, Dr. Biermer refers Dr. Beale's valuable paper in the 35th vol. of the *Medico-Chirurgical Transactions*, and with truth bears testimony to the value of his contribution to the pathology of pneumonia.

Dr. Biermer proceeds to describe the mode of analysis which he adopts in his examination of the sputa, the quantitative and qualitative, and alludes to the methods employed by Pearson and other writers, which have fallen into disuse owing to the advancement of science.

The reaction of the sputa should be determined, not that it has any very great weight in itself, but that it indicates the way to further inquiry; for example, if the sputa be acid, it often shows that the contents of the stomach are mixed with the expectoration. The second chapter of Dr. Biermer's work is devoted to a description of the morphological constituents of the expectoration.

Epithelium cells form a constant constituent of the sputa. The pavement, and the cylinder, with or without the ciliated. This is what may be expected, if, as Henle states, a continuous desquamation of the mucous surfaces is going on. Epithelium cells, seen under the microscope, present the appearance of elliptic discs, the surface often irregular and wrinkled. The quantity of pavement epithelium is augmented in disease, in diphtherite, &c., and also when the amount of saliva secreted is considerable, as in ptyalism.

In the sputa expectorated by healthy men in the morning, there is much epithelium. This fact had been noticed by Simon. In speaking of epithelial desquamation, he says:—"The clots of mucus expectorated in the morning by men otherwise healthy, on being examined with the microscope, contain merely epithelial cells."

Pathological changes are also observed in the epithelium. The cells undergo a fatty degeneration, which is seen in all its stages, and occasionally pigment cells are present, not merely in tuberculous, but also in catarrhal expectoration. The views of some authors as to the presence of melanotic cells indicating a lesion of the lung parenchyma, must be received with limitation. In pneumonic sputa, young epithelium-like cells, with pigment, varying in hue from a golden yellow to black, have been observed.

The presence of *blood* in the sputa next engages Dr. Biermer's attention. In the greater number of cases the microscope is not necessary to indicate the presence of blood in the sputa; it is only where the quantity is small, and that it is intimately mixed, there can be a doubt. The microscopic appearance of the blood corpuscles is familiar to most persons; they are distinguishable from all other cell constituents of the expectoration, by their bi-concave disk-like form, their central depression, their sharp contour, and their reddish yellow colour. In pure hæmoptysis the blood corpuscles are unchanged, they lie with their surfaces on each other, and are united into rouleaux. In sputa tinged with blood, for example, in laryngeal phthisis, or bronchitis, the corpuscles generally are found touching each other, not at the surfaces, but the edges.

The explanation offered by Hoefle to account for this phenomenon does not appear plausible to Dr. Biermer, who believes the cause of the blood corpuscles only touching at the edges to be the mechanical act of expectoration, whereby the corpuscles are torn from each other, and the surfaces are, as it were, smeared with mucus.

In general the blood corpuscles undergo little change in the sputa, but they do sometimes, when we observe them to assume a pear-like form, or to be distended into a spherical shape, and also they may become shrivelled, granular, and devoid of colour.

Dr. Biermer next brings under notice the *exudation cell formation*. The pus corpsuscle he considers the representative of the perfect exudation cell, its form is spherical, its surface granular. To observe the interior, dilute acetic acid is necessary, by which one large, or some small nuclei may be seen. From the mucous corpuscle the pus corpuscle is distinguished by its rough and granular appearance, its thicker cell membrane, and its numerous nuclei.

The exudation cells are smaller than the pus cells, regularly round, of sharp contour, and not very granular in appearance. The mucous are larger, and have a distinct nucleus, but in other respects resemble the exudation cells. In some cases large, round cells, filled with numerous nuclei, are met with in the sputa. With respect to the distinguishing pus corpuscles from all other elementary bodies, Wedl informs us, in his "Rudiments of Pathological Histology," that we have in dilute acetic acid a ready means, and that the manifestation of the multiplo-nucleus is so characteristic, that we can always distinguish them from the young connective tissue cells. The fatty metamorphosis invades all the cell formations of the sputa. Wedl says the fatty metamorphosis of pus corpuscles is manifested by the appearance within them of strongly defined, brilliant molecules, which are not removed by the action of dilute acetic acid, or of a solution of carbonate of soda or potash.

In the sputa of pneumonia are exhibited numerous cells which have undergone the fatty metamorphosis. The presence of *pulmonary tissue* in the sputa has been indicated by many writers on thoracic disease, and of late has excited much interest. Vogel, Lebert, Bühlman, Watts, Schröder van der Kolk, may be named as having contributed to our knowledge on the subject, but Remak is the author who has devoted especial attention to the subject. In this country Dr. Watts brought under the notice of the profession a case in which portions of tuberculous lung were expectorated. In 1846 he exhibited to the Manchester Pathological Society a portion of expectorated lung, and illustrated the minute anatomy of the preparation by a drawing of the contractile fibres of the pulmonary parenchyma, magnified 500 linears.

Dr. Watts stated that he had frequently found particles of tuberculous lung, and had often discovered the existence of a tubercular cavity by these means; and that in an obscure case he was enabled to form a correct diagnosis, in which it would otherwise have been difficult to say whether the disease of the lung was mere induration, or induration with tubercles, or apoplectic induration, or a tubercular cavity, or simply an abscess. The microscopic examination of the sputa made the existence of a cavity a matter of certainty. Remack has diagnosed tuberculosis of the lung by the presence of elastic fibres in the sputa, in cases in which, without this, there was no symptom which could be depended upon.

They occur in two forms—free in the sputa, or enclosed in white, thready, fibrinous masses. The first is found, as a rule, in the early stage of phthisis, when the expectoration is scanty; the second, from one to four lines, in the advanced stages of the disease. Remack thinks that the fine, thread-like lymph comes from the minute bronchial tubes which surround the caverns, and that their existence has a therapeutic signification. Two kinds of lung degeneration are distinguished by the two forms under which the elastic fibres appear in the expectoration. The first, which corresponds with the elastic fibres free in the sputa, is not of an inflammatory nature, and consists of simple lung destruction; whereas, in the second, inflammation exists around the tubercles, lymph is thrown out, in which, on being expectorated, elastic fibres are found. When the elastic fibres are numerous, or appear in the sputa as large bundles, according to Remack, there is ground for apprehension that the blood-vessels, being eroded, hæmoptoe would supervene. When new caverns are being formed in the lung, the elastic fibres are most frequently present in the expectoration. In those cases in which old caverns with thick walls are recognized by auscultation, the fibres are absent.

Dr. Biermer's investigations on this subject do not exactly point to similar results as those arrived at by Remack. He did not, in the first place, find the elastic fibres nearly so frequent a constituent of tubercular expectoration, albeit he examined a vast number of specimens of tubercular sputa with the utmost care, nor could he derive from their presence the minute knowledge as to the pathological state of the lungs which Remack had done. Respecting the mode of examination, Dr. Biermer says the elastic fibres are to be sought in muco-purulent sputa, presenting grey spots or filaments. The sputum of the spitting-vessel should not be selected, but the patient should be directed to expectorate three or four times on paper, or on a plate.

As to the *diagnostic value* of these elastic fibres in the sputa, Dr. Biermer considers their presence at an early stage of pulmonary disease, where there are no other signs of organic change, as pathognomonic of commencing phthisis.

At a later period, especially when satisfactory signs, derived from percussion and auscultation, may be absent, the elastic fibres may be considered as indicating, with tolerable certainty, destruction of tissue, and the formation of a cavern. Again, the absence of expectoration containing elastic fibres, may give reason to hope that the healing of the cavern is in process. Wedl, in speaking of the contents of tubercular caverns, says—"When the organic detritus is not so completely disintegrated, detached pulmonary fibres may be seen in the pultaceous contents of the cavern, and may be readily recognized by the peculiar way in which they are curved. These fragments should be looked for in the sputa of phthisical patients, and are of diagnostic importance, as indicating a loss of substance in the pulmonary parenchyma. According to Schröder van der Kolk, they are more likely to be met with in the sputa, in cases where small caverns exist in a state of progressive development, than where large ones are present, in the advanced stage of phthisis."

(*To be continued.*)

DUBLIN: PUBLISHED BY W. B. KELLY,
8, GRAFTON-STREET.
LONDON: S. HIGHLEY, 32, FLEET-STREET.
EDINBURGH: MACLACHLAN & STEWART.
November 15, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.
SENT FREE BY POST.
Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 21.—Vol. II. DECEMBER 1, 1855. Price 5d.

Lectures on Diseases of the Stomach.

BY DR. LEES,

PHYSICIAN TO THE MEATH HOSPITAL, LECTURER ON PRACTICE OF MEDICINE.

No. III.—*Sub-acute Gastritis; Symptoms; Diagnosis; Causes; Treatment.*

Although acute idiopathic inflammation of the mucous membrane of the stomach is very rarely met with, yet a state of irritation, or sub-acute gastritis, occurs frequently as a result of the stimulating properties of wine or spirituous liquors; and though we seldom have an opportunity of seeing the condition of the mucous membrane under such circumstances, yet Dr. Beaumont informs us that on several occasions, after a fit of intemperance, he found St. Martin's stomach red, dry, and erythematous, or coated with adherent viscid mucus, and that patches of apthæ or abrasions were also often met with, as a result of such irritation. Patients suffering from this disease complain of general discomfort, a sense of oppression and distention at the epigastrium, which is tender to the touch; there are flatulence, nausea, and a sensation of heat and fulness in the stomach, especially after taking food, no matter how small in quantity, or of how simple a kind. Acid, acrid eructations are very distressing, and they suffer from dryness and irritation—often actual inflammation of the throat and fauces; there is thirst for cold drinks, especially during the process of digestion, when the pulse is quickened, and there are frequent retchings and vomitings, especially after anything taken into the stomach, the matter vomited being generally ropy, colourless, and abundant, or coloured with bile; there is a state of general malaise, great depression of spirits, and prostration of strength; a dark or sallow circle round the eyes, which are sunken in their orbits, and total loss of appetite. They complain of an unpleasant, dry prickling sense of heat in the palms of the hands and the soles of the feet, especially towards evening; the tongue is red at the point and edges, or coated with a thick fur, indented by the teeth; the bowels are generally costive, and the evacuations dark-coloured and highly offensive; the skin is dry at first, but there is often a great tendency to perspiration, particularly at night; the urine is scanty, high-coloured, acid, and depositing lithates. They often suffer from severe frontal headachs, vertigo, pains in the back and limbs, palpitation and cough, of a hard, paroxysmal character, which may be so severe as to draw the attention away from the stomach symptoms, an example of which occurred in the case of a young gentleman whom I saw in consultation with his usual medical attendant, who supposed him to be in an advanced stage of consumption; and, certainly, the extreme emaciation, constant cough, and profuse nightly perspirations, appeared to justify his suspicions; but after carefully exploring his chest, and not being able to detect any physical sign of disease, I came to the conclusion that the symptoms of disease of the lungs were merely sympathetic, a further examination satisfied me that the stomach was the organ at fault, and the successful result of treatment directed to that viscus confirmed me in my opinion. The diagnosis of such cases (in which we are in doubt as to the origin or connexion of pulmonary disease with gastric irritation) is often very difficult, as the extreme emaciation and profuse nightly perspirations are liable to deceive, and leave us to pronounce the case as one of tubercular phthisis.

In hooping cough, also, it is sometimes difficult to decide whether the constant vomiting be kept up by gastric irritation; and in those troublesome cases, met with in young females, in which vomiting occurs frequently in connexion with paroxysms of severe cough, it often depends as much on gastric irritation as on the convulsive action of the respiratory organ. In all these cases, therefore, we must institute a careful examination into the previous history and symptoms, as well as the existing physical signs, when, if the stomach be the organ at fault, we will find that the primary symptoms were referred to this viscus. The face generally presents a fretted, anxious, painful expression; there is a circumscribed patch of redness on one or both cheeks; the lips are dry, scaly, cracked, and often bleeding, as they are constantly picking them; the eyes are sunken and dull, with a yellow tinge of the conjunctiva; the tongue is red, dry, and fissured; the papillæ very prominent, and it is often covered with apthæ; the bowels are very irregular, the evacuations dark-coloured and highly offensive. This is a very dangerous form of disease, particularly when it attacks young girls or children, or if it supervenes at an advanced period of other diseases—as simple continued fever, or any of the inflammatory affections, as pneumonia; there is a peculiar rawness and tenderness of the whole mouth and throat, with a dry and glazed appearance of the tongue, a deep redness of the pharynx, which, in some cases, presents one continued dense crust of an apthous character; there is tenderness on pressure in the epigastric region, with pain along the course of the œsophagus, and great uneasiness in the stomach, excited by the mildest articles of diet. In some cases there is constant vomiting, in others, both vomiting and diarrhœa; in fact it then assumes the character of what is popularly termed gastric fever—the intestines become distended with flatus, there is hiccup, low muttering delirium, stupor, subsultus tendinum; in short, all the symptoms of bad typhoid fever, and they die either of exhaustion by sudden syncope, or rapid effusion takes place on the brain, or bronchitis supervenes, and appears to be the cause of the patient's death.

The treatment of the milder forms of sub-acute gastritis is simple, for as they are mostly caused by errors of regimen, a mild farinaceous and abstemious diet will suffice for their removal; but in some constitutions, particularly if neglected, the complaint, though mild at first, becomes very serious, and often tedious, requiring great skill, care, and judgment, for there is no disease in which you are more liable to lose the confidence of your patients or their friends, unless you explain the nature of the case, its uncertain duration, its liability to relapse, and its occasionally fatal termination. The late Dr. Cheyne, one of our most successful practical physicians, remarked, with reference to this disease, that, "long and watchful practice confers no greater boon than in enabling a physician to be inactive without loss of character, or the danger of being supplanted by those who think it necessary to practise, not only for the benefit of their patients, but on the credulity of their friends or attendants." The chief points in the treatment are: first, to allay inflammation by the application of leeches, according to the urgency of the case, the age and previous condition of the patient; second, not to irritate the mucous membrane by a farrago of medicines, but content yourself by treating the most prominent symptoms. Two grains of mercury with chalk, or magnesia, at night, or the same quantity of blue pill, combined with a grain of extract of hyoscyamus or lactucarium, given for the first eight or ten nights, will allay irritation and promote healthy secretion; if there is much irritability of stomach, give one or two drops of dilute hydrocyanic acid with three grains of bicarbonate of soda in an ounce of distilled water, every two or three hours; if the skin is very dry, give two grains of nitre in an ounce of water or almond emulsion every two or three hours, and allow small quantities of mild fluids to be drank at a time, either barley water, or gum and water, or equal parts of milk and soda water or seltzer. Be very cautious of purgatives, as a very small dose of medicine often exerts a powerful effect, so, if an aperient is required, give phosphate of soda in weak chicken broth, or a solution of magnesia or soda with lemon-juice; but it is safer to regulate the bowels by enemata. If the discharge from the bowels be very frequent, or serous, or mucous, you must check them by small enemata of starch, one to three ounces, with from two to fifteen drops of laudanum, according to the age of the patient; if the evacuations be very offensive or pungent, have some peat charcoal always left in the utensil, or you may give charcoal prepared from wood (of the poplar if possible), very finely powdered, in doses of ten or twenty grains. After five or six days you may allow them chicken broth or beef tea, and if the bowels are regular, and there is tendency to perspiration, the mineral acids will now prove beneficial—twenty minims of nitric acid, with thirty of muriatic, in eight ounces of water; an ounce every three or four hours will be agreeable to the palate, tend to quench thirst, remove the clammy, disagreeable taste from the mouth, and allay morbid irritability. When there is great tendency to constipation, I have found small doses of sulphate of quinine, with sulphate of potash, and dilute sulphuric acid to agree very well; wine will often be requisite, but you must commence its use carefully.

A table spoonful of sherry, or claret, or some of the Rhenish wines, diluted with water, and given every three or four hours, will be sufficient to commence with; but no point of practice requires greater consideration than the giving or withdrawing wine in this form of disease, for there is a tendency to debility and prostration of the powers of life at all periods of inflammation of the gastro-intestinal system, and this condition will be aggravated by wine given at an early period; but in the advanced stages, when the pulse is small, irregular, or unequal, when the impulse of the heart is feeble and its sounds indistinct, when the circulation in the extremities is languid, you may then give wine freely, or even whiskey or brandy; a tea-spoonful in a cup of warm milk, or arrow root, or sago, every hour, according to circumstances, may be given with advantage. If there be much tympanitis, it is best treated, in the early stages, by turpentine fomentations and enemata; but in the latter stages, turpentine may be given internally in half-drachm doses; and if there be much febrile irritability at night, with want of sleep, they will derive much benefit by having the legs and feet sponged with tepid water and vinegar, or dilute nitro-muriatic acid.

With regard to the diet: in all forms of subacute gastritis, it is necessary, in regulating it, to have reference to the stage and degree of the inflammation and the state of the system. You should remember that the stomach, though in a state of inflammation, yet is the viscus through which the system is nourished, so that though it might be desirable to restrict the diet rigidly if we only regarded this organ, yet we must bear in mind that the whole system may suffer; and the stomach itself be injured by extreme abstinence, when the system is requiring support. Such are the sympathies of this viscus with the other parts of the system, that the suffering caused by deficient nutriment in remote parts, is reflected upon it with especial force, and the stomach may thus be inflamed though the body is sinking from inanition, as was proved in the experiments of Andral and Gavarret, which I mentioned in the previous lecture.

Clinical Lecture on some Cases of Partial Paralysis.

BY DR. M'DOWEL,

PHYSICIAN TO THE WHITWORTH AND HARDWICKE HOSPITALS.

There are at present in the hospital some interesting cases of partial paralysis, to which I would particularly direct your attention.

Partial paralysis (an inaccurate term, but one universally adopted) is generally presented to us in some of the parts supplied by the cerebral nerves. The nerves most frequently engaged are the third, fifth, and seventh pairs. Hemiplegia and paraplegia are, no doubt, strictly speaking, examples of partial paralysis, *i. e.*, of paralysis of part of the body; but such is the vagueness of medical nomenclature, that these latter are usually regarded as instances of general paralysis: partial paralysis is much more narrowly localized. Pathology, perhaps, reconciles the apparent anomaly. Hemiplegia and paraplegia are essentially the result of some central lesion—of the brain in the former, of the spinal cord in the latter instance (I speak of what exists in the great majority of instances); but partial paralysis, though it may undoubtedly be of centric origin, yet very frequently exists as a local and superficial affection. At the same time, partial paralysis may occur in the extremities. I have met with a remarkable group of cases, in which sensation was wholly lost in the greater part of one lower extremity, motion being unimpaired. Again, there may be partial paralysis of motion of one leg or of one arm, without any impairment of sensibility. Such cases are often associated with hysteria, and may be curable. Hysterical retention of urine is, in some instances, I imagine, an example of partial paralysis.

But to come to particular instances. The first case I shall direct your attention to is that of a man named Connor, in No. 1 Ward. A year and a half ago this man first came under my observation. I shall read the notes of his case, as they were then recorded, and we shall find his symptoms to be divisible into two distinct groups.

Case.—Pat. Connor, æt. 22, a shoemaker, admitted into Whitworth Hospital, April 12, 1854. Patient's appearance is extremely unhealthy; he is pale, emaciated, and languid-looking; his manner is stupid and listless; his memory is defective; and he suffers from severe pain in the right parietal and frontal regions.

First Group of Symptoms.—The right side of the face and the right eye-ball have lost their sensibility; needles can be introduced into this side of the face, and the eyeball can be touched, without exciting uneasiness. The right side of the tongue has also lost all gustatory power; sugar and salt, for example, cannot be discriminated; but, worse than this, in his own estimation, the patient says "he cannot get the taste of the oil when he is smoking his pipe at the right side of his mouth. Sensation in the lips is not so completely annulled as in the other parts supplied by the fifth pair, as the patient, when he drinks, can recognize the contact of the vessel on the right side, and hence the latter does not seem to him to have part of the rim broken, as is generally observed when the sensibility of half the lips is entirely lost. Mastication is performed equally well on both sides; the right nostril is drier than the left.

These symptoms indicate a lesion of innervation affecting the sensitive portion of the fifth pair of nerves—the nerve which gives sensibility to the cutaneous surface and to the mucous membranes and cavities of the head and face. Observe the special or pathognomonic signs of this affection, which, in the language of Andral, is called *anæsthesia*. Loss of sensibility of half the face; insensibility of the surface of the eye, and of the corresponding nostril, parts so acutely sensible to external impressions in the healthy state; dryness of the nostril on the affected side, because secretion, which depends on a healthy condition of the nerves, is necessarily arrested; lastly, loss of the sense of taste on the same side of the tongue (*ageustia*), because the gustatory nerve—a division of the fifth pair—conveys not only ordinary but also special sensation. The motor portion of the fifth nerve was unaffected, and hence mastication was not interfered with.

Now, when this patient was readmitted, in September last, all the symptoms above described had disappeared; the functions of the fifth pair of nerves had been restored, and there was no longer any evidence of anæsthesia; but there still existed a nervous lesion, which we had on that occasion carefully observed, and which you can all study in the case at present. This lesion was and is still characterized by the following symptoms:—

Second Group of Symptoms.—The right eyeball is directed very much outwards, and can neither be turned upwards, downwards, or inwards; the upper eyelid cannot be elevated so fully as on the left side; whilst the pupil is widely dilated, and is not urged to contraction by even the strongest light. We learn also that double vision is excited whenever the patient looks upwards or downwards with the left eye. These symptoms depend upon a lesion of the third pair of nerves.

[It was shown on a model and on plates that this nerve supplies five of the seven muscles of the orbit, viz., the superior, inferior, and internal recti, the levator palpebræ, and the obliquus inferior; and that, by a communicating branch to the lenticular ganglion, the third nerve also conveys motor influence by the ciliary branches of that ganglion, to the iris.]

When this nervous channel is interrupted, the superior, internal, and inferior recti muscles are paralyzed; and, as there is no opposing or antagonistic force to the external rectus, the eyeball is directed outwards by the *tonic contractility* of that muscle, giving rise to strabismus, which becomes much more developed when the muscle is thrown into *active contraction*. It can also be understood that the pupil is widely dilated, owing to the same cause. Double vision in such cases has been attributed to a lesion of the fourth pair of nerves, but its occurrence can be otherwise explained by the alteration in the axes of the two eyes, and the consequent development of the image of external objects upon portions of the two retinæ which are not naturally *consensual*.

The phenomena in this case might be arranged in the form of a problem. Given, a case of divergent strabismus of one eye, with inability to direct that eye upwards, inwards, or downwards, and with permanent dilatation of the pupil (mydriasis), to determine the lesion. You already know the answer; the lesion is one of the trunk of the third pair of nerves on the right side.

The symptoms of diseases of the nervous system can, in many instances, be thus reduced to a formula, and as the physiology of these structures becomes more accurately understood, the number of diseases in which this can be done will become more numerous. A little more than thirty years ago we could not have thus decided on the nature of such a case; but about 1825, Sir Charles Bell commenced those investigations into the functions of the nerves to which we are so much indebted for our present knowledge.

We have here a beautiful illustration of the mutual assistance which physiology and practical medicine can confer on each other, in determining the functions or uses of particular structures.

In order to learn something of the origin and cause of this compound affection of the third and fifth pairs of nerves, the symptoms of which we have now determined, we turn to the *previous history* of the case, which tells us that four years ago this patient had syphilis and was mercurialized; two years ago, when bathing, he jumped from a considerable height into the sea, and very soon afterwards was attacked with severe pain in the head, which lasted at intervals for several days, when he remarked that objects appeared double, then ptosis of the right upper eyelid occurred, and for a week vision was interrupted from this cause. Subsequently the movements of the eye became more limited, but he was not aware of the existence of anæsthesia until it was demonstrated to him in the hospital.

I believe that we have here a syphilitic affection of the fibrous membrane enveloping these nerves, or of the fibrous periosteum (part of the same expansion) lining the foramina through which they pass. The patient gives the history of syphilis, and other symptoms existed which are referrible to this taint; we find that his mind was affected, that his memory was much impaired, and that there was a listlessness and a stupidity about the man which we can now see was not natural to him. Since the patient has been a second time under observation, we find, as confirmatory of this opinion, that he suffered severely from nocturnal pains, and that a tender puffy spot, as large as half-a-crown, existed over the lateral aspect of the right occipital bone, in fact, syphilitic periostitis. On this supposition he was treated. Iodide of potassium was given, and latterly the node, when it was detected, was freely blistered.

That the partial paralysis in this case did not depend on central disease of the brain, or on an intracranial tumour, is proved by the progress of the case. You observe the lesion of the fifth nerve has disappeared, the levator palpebræ is no longer paralysed, and lately we have observed that the internal rectus has regained some power, for the patient is now able to direct the eyeball forwards, though he cannot yet direct it inwards. Corresponding with this gradual disappearance of the signs of partial paralysis, the patient's general health is much improved, his apparent stupidity has disappeared, he is cheerful and intelligent, his memory is no longer defective, and the periosteal pains and swellings have also vanished.[*]

The subject of syphilitic affections of the membranes of the brain is one of great interest. Dr. Todd of London, and Dr. Read of Belfast, were, I believe, the first to recognize these affections, and to insist on their importance. These authors have shown that in some instances epilepsy, paralysis of the limbs, loss of memory, and impairment of the mental powers generally, may depend on such an affection, and I think I have now shown that partial paralysis may have a similar origin. The importance of such a case with reference to prognosis is sufficiently obvious.

The other case to which I wish to direct your attention is one of a compound affection of the fifth and seventh pairs of nerve. It is that of a young woman in No. 4 Ward, and may be thus briefly described:—

Case.—The patient came under observation October 24. Six weeks previously she was suddenly attacked with intense pain in the right side of the face, shooting along the teeth, and up to the temple and eyeball. The attacks of pain used to come on at various times of the day and night, lasting generally for several hours; but latterly the paroxysms have been strictly periodical, coming on punctually at eleven o'clock in the forenoon, and terminating at 5 P.M. During the attacks of pain there is puffiness, and an increase of temperature of the right side of the face, with a profuse flow of saliva from the mouth; at the same time the eyes became tender and suffused.

We have here a description of acute neuralgia of the face, popularly known as "face ache," or *tic douloureux*. This disordered condition of the nerves is technically termed *hyperæsthesia*, and is the antithesis of that affection which is characterized by loss of sensibility, and which we have already considered under the name of *anæsthesia*. The branches of the fifth pair are the nerves which are engaged in these contrasted affections; but in this case we find evidence of a lesion of the portio dura nerve likewise (which is the motor nerve of the superficial muscles of the face), for we read that the face is distorted, the mouth being drawn to the left side; that the filtrum is directed obliquely; the right cheek droops and is placid, and the power of elevating the right corner of the mouth is lost. The morbid action, which originated in the branches of the fifth pair, would appear to have extended to the branches of the portio dura of the seventh pair —anatomy explains how this might occur. These nerves leave the cranium by widely separated openings. The portio dura, as it becomes more superficially placed, shoots its branches horizontally across the face, distributing them to the superficial muscles. The branches of the fifth pair reach the face by three foramina, placed exactly the one above the other; deeply situated at first, these branches become superficially placed in order to reach the integument, and now a free anastomosis is established between these and the filaments of the portio dura; hence any morbid action, set up in the extreme branches of one nerve, may readily travel to those of the other.

This view of the case will explain why the paralysis of the muscles, supplied by the portio dura, is only partial in this instance, the cervico-facial, or lower, division alone seems to be engaged, whereas, when the portio dura is primarily affected, the entire of the nerve is engaged, and in addition to the symptoms already described, the lower eyelid cannot be elevated (from paralysis of the orbicularis palpebrarum); hence the lower half of the eyeball is permanently uncovered, whilst the corresponding half of the forehead is smooth, and cannot be wrinkled.

Neuralgia of the face is not usually accompanied by partial paralysis, but as I have met with this complication before, I wished to show you how such an occurrence might be explained. You will often be called on to treat facial neuralgia, and hence should have a practical knowledge of the subject. Some are satisfied to regard it as a "neuritis," and to treat it accordingly; but this I know, that local depletion, or any of the depressing agents, usually given in inflammation, such as tartar emetic, aggravate the affection; hence, also, mercury is, to say the least, unnecessary. If inflammation be present, it is of a *specific* kind, perhaps something akin to the rheumatic inflammation, involving, not the nerves themselves, but their fibrous sheaths. Exposure to cold is generally regarded as the cause of these attacks, and very often it is the exciting cause; but some constitutional derangement will generally be detected, without which the influence of external agents would be powerless to produce the disease. Disorders of the digestive system in many instances precede these attacks. In females, disorders of the uterine functions are the prolific source of neuralgia. But however provoked, observe the extraordinary tendency of the disease to remain established in the nerves. In this young woman the disease, after six weeks, was just as bad as it was at first. But you should learn that this is so common, as to be almost *a law* of deranged nervous functions. Tetanus, epilepsy, hysteria, may originate in trifling and apparently insignificant causes; but the morbid action, once set up, may continue in spite of the best directed treatment. The disordered function becomes, as it were, a habit, and the resources of art are exhausted to find something to break the chain of morbid sequences. In the case before us there was a loaded tongue, with loss of appetite, so an emetic was given, which alone gave much relief. A mercurial purgative followed next. The vapour of chloroform, locally applied, gave relief to pain, but its good effects were very transitory. Aconitine ointment locally, and sulphate of quinine, *in full doses* (eight grains), gave marked and permanent relief. When the attacks are decidedly intermittent, quinine, thus given, in the intervals between the paroxysms, will generally cure the disease; if it fail, iron may then be used. Blisters were also applied to the parotid region, with a view to remove the paralysed condition of the muscles. The further progress of the case will be brought before your notice; but, although it is so far imperfect, still having noticed a compound lesion of the fifth and third nerves, I thought it a good opportunity to comment thus briefly on the second case, which exhibits a compound lesion of the fifth and seventh nerves.*

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[*] An argument against the existence of central cerebral disease or of intracranial tumour, might apparently be derived from the *limitation* of the paralysis to the parts supplied by two nerves only. But in a case recorded by Dr. Mayne, in the Reports of the Pathological Society, although the symptoms, up to the time when the patient suddenly died, were limited to those of paralysis of the parts supplied by the third nerve, yet after death there was found an aneurism of the posterior cerebral artery, which pressed on the trunk of that nerve, and so produced the symptoms which existed in the case above detailed.

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* The case last described left the hospital a week afterwards greatly relieved; the pain had become much slighter, and of shorter duration each day; and the paralysed condition of the face was almost entirely removed.

Cases of Disease of the Rectum, with Remarks.

BY CHRISTOPHER FLEMING, M.D., M.R.I.A.,

SURGEON TO THE RICHMOND HOSPITAL.

At page 81 in Vol. I. (N.S.) of this Gazette, under the above heading, I have recorded some cases of "Prolapsus of the rectum," and I now beg to add the following of "Chronic ulceration," and of "Stricture," involving that portion of the intestinal tract.

Case I. *Chronic Ulceration of the Rectum.*—John Fullam, aged 56 years, a public van-driver, applied to me in October last, labouring under symptoms much resembling those of chronic dysentery. He stated that they had commenced about five months previously, and that they were now so distressing he was obliged to seek hospital relief—that he had constant and urgent desires to go to stool—that the discharges which escaped were thin and slimy, and were often deeply coloured with dark blood—that they rarely contained fæculent matter, other than in small, irregular, and detached portions, and that this was more frequently fluid or semi-fluid than of other consistence; that his general health did not materially suffer, and that he would even now continue his occupation, but that being obliged to remain from eight to ten hours daily on his box, during six days of the week, he found it no longer manageable, in consequence of his repeated calls to stool. On more close examination, I found that in appearance he was tolerably healthy—that many of the *general* signs of dysentery were wanting—that the abdomen was free from any appreciable amount of fulness or tenderness in any of its regions—and that his special suffering was localized in the rectum and in its immediate vicinity. There was no vesical irritation of any amount; the pain he suffered was more severe after discharging the bowels, and was of a lancinating character, passing towards the sacral region, and the neighbourhood of each hip joint, particularly the right, but it was yet very tolerant.

Proceeding to examine the rectum, I perceived nothing at or about the anus to excite the suspicion of disease within the gut. There was only visible a small external hæmorrhoid, but it was of no moment. On now introducing the finger, when it reached to about the second joint, a sensation was communicated, as if the rectum was loaded with hardened fæculent masses, and after the action of a full enema, this same sensation was present. On more close examination I found that this arose from the uneven border of a deep and excavated ulcer which occupied the back wall of the gut; that the circumference of this ulcer was not less than that of a half crown piece, and that the base of it, when pressed on, was equally hard and irregular, the remaining portion of the bowel being, as far as could be ascertained, perfectly healthy. I admitted this man into hospital—kept him as much at rest as possible in the recumbent posture, and put him on mild nutritious diet. His bowels were regulated by the exhibition of small doses of castor oil, and occasional emollient enemata; a slight mercurial effect was produced by moderate use of blue pill and Dover's powder combined; this was followed by iodide of potass and sarsaparilla, and hip baths and astringent or anodyne injections were administered as required. At the expiration of a month, an amount of benefit was experienced which was surprising; the local irritation materially subsided; the acts of defæcation were stated as being free from uneasiness, and of much less frequent occurrence; the dark, coffee-coloured discharges of mucus and pus remarkably diminished; and improvement took place to such an extent, that the man, after a month, desired to leave hospital and return to his work. With respect to the ulcer, no satisfactory change was effected, as ascertained by touch — its distance from the anus, and its situation, not admitting of any satisfactory view with the assistance of the speculum. The same local characters remained, it had not apparently increased in extent, but the hardened and irregular edges and surface were distinctly traceable by the finger, yet decided diminution took place in the quantity and quality of the discharge; the former was much less, and the amount of blood in the latter very trifling, and, moreover, the man was not disturbed at night as heretofore, and even throughout the day he was, from his statement, tolerably free from annoyance.

Case II.—*Stricture of the Rectum.*—Philip Campbell, aged 27 years, a horse-shoer by trade, was admitted into hospital on the 16th of November, ostensibly with "fistula in ano." He is an unhealthy, pallid-looking man, with all the usual indications of a scrofulous habit. Although he does not allow that he is sick in the ordinary acceptation of the term, it is yet too obvious that his constitution is materially impaired. He refers his principal sufferings to the anus and rectum. For ten years he has been the subject of them, and he attributes their origin to cold and damp. About this period his bowels became irregularly constipated, and constantly required medicine to regulate them; the discharges were rarely healthy, and they were often tinged with a muco-sanguineous fluid, which latterly escapes almost involuntarily in the erect posture, and constantly on making the slightest expiratory effort. The forcing and straining at stool are considerable, and often most distressingly painful, and give exit to flatus, and the discharges above noted, accompanied with little or no fæculent discharge. These symptoms have continued with more or less intensity, and have had superadded at different times copious hæmorrhage from the bowel. About three years back the latter was so severe that he was obliged to procure admission into St. Vincent's Hospital, where the bleeding was restrained, but all the other symptoms remained unrelieved. During this lengthened period he continued, to the astonishment of his family, at his laborious work, and applied for no regular medical or surgical advice. About a month or six weeks back considerable inflammation occurred around the anus, and abscesses formed which terminated in some fistulous openings, discharging matter and flatus, and adding much to his distress; he is, moreover, latterly subject to shiverings, which occur at irregular periods, and are followed by feverish attacks of uncertain duration; whilst they continue he has much irritability of the stomach, and all the local symptoms of his complaint are increased. On investigating the latter, evidences of extensive disease present themselves around the verge of the anus and in the rectum. The integuments of the former are thickened and discoloured, and towards its lateral and posterior part a pendulous prolongation exists, reddened and œdematous on the outside, and its mucous surface partially ulcerated; fistulous openings are also to be seen leading by a sinuous course under the skin towards the rectum, and evidently communicating with it. The finger detects within the gut extensive ulceration, and at about from an inch and half to two inches it is obstructed by a thick shelving partition, which completely surrounds its point, and merely admits it when some force is applied; any portion of the bowel which can be reached feels dense, contracted, and roughened, and closely presses on the finger as it advances. Not much pain is complained of in the examination, but it is followed by considerable bloody oozing, and great caution is hence required in the use of either speculum or bougie, from the irregularities which present themselves. There is no unnatural fulness or uneasiness traceable in the abdomen, and although a general delicacy of constitution is manifest, no organic lesion is discernible. The result of treatment cannot be otherwise than palliative. The action of the bowels is secured by suitable aperients, as in the case above detailed. Preparations of iodine and other tonics are being exhibited with a view to the general health, and bougies and medicated tents are contemplated to improve the condition of the rectum.*

Remarks.—The lengthened details given in the report of the above cases (which, it is to be recollected, were arranged for clinical instruction) almost dispense with the necessity for any remarks respecting their nature and treatment, as all surgeons must be cognizant of the more important points attendant on both. If those cases, however, be placed in juxta-position, and if the history and symptoms of each be carefully analysed, it will, I think, be admitted, that substantive grounds exist for the opinion, that they stand in the relation to each other of cause and effect, and hence that they are worthy of record, although most materially differing from each other in their essential nature. In my clinical observations I have noted this fact as important in directing the attention to the prominent symptoms of each case, and so guiding the treatment. In the first case, as in many other such, no external clue existed to indicate the presence of an ulcer within the rectum, even when it had advanced far, and had engaged a considerable portion of the walls of that gut, and it would, perhaps, have escaped detection, had not accidental circumstances led to special examination. That that ulcer is malignant is much to be apprehended, and that it will, if life be prolonged, implicate the whole circumference of the bowel, and so terminate in stricture, can hardly be questioned. If seen in this, the more advanced stage, it would be placed under such denomination as is noted in the second case, in which the initiative morbid action was certainly also ulcerative, and ulceration within the gut comparatively painless and insidious, lasting for a series of years—lupoid, most probably, in its character; and slowly, but surely, extending its devastating effects, and terminating in complete obstruction of the gut from its irregular progress to ulceration or cicatrization. That such affections of the rectum are lupoid can hardly be questioned; their slow, insidious, and recurrent course identifies them with such morbid action; the period of life at which they occur favours the opinion, and identifies them with similar forms of disease so commonly involving the pharynx, the tongue, and the mouth, and occasionally, though rarely, the vagina in the female and urethra in the male. In their ultimate results, such lupoid affections of the rectum bear no small resemblance to those remarkable deformities which almost daily observation familiarizes the surgeon with as they present themselves, especially in the fauces and pharynx, and as is beautifully shown in some drawings in the museum of the Richmond Hospital, where a very limited communication exists between the mouth and pharynx, from the abnormal adhesion in the progress of such disease, of a remnant of soft palate to the back of a pharynx, totally altered from its natural course and in its natural structure. Identical changes will be found as the result of similar morbid actions in the walls of the rectum, creating in the mind of the surgeon equal surprise that life can be sustained and nutrition so well accomplished, with an outlet very limited indeed in its calibre. The supervention of recurring abscesses and undermining fistulæ in the protracted stages of such cases is to be expected; and accompanied, as they often are, with the peculiar condition of the verge of the anus described, at once points out the necessity for special examination previous to attempting any operative proceedings.

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* The above cases are taken from notes furnished by Messrs. Wallace and Cruise, pupils in the hospital.

Case of Chorea, treated by the Application of Splints, &c.

BY T. L. MONAHAN,

PHYSICIAN TO THE NORTH UNION WORKHOUSE, DUBLIN.

Anne Fitzpatrick, a widow, æt. 34, of low stature and stout make, had one child nine years ago; states that she enjoyed excellent health until 2nd of November. On that day she was travelling by rail, from Bradford to Liverpool, when quite suddenly, and without any premonitory symptoms, she was seized with stiffness between the shoulders, and involuntary motions of both arms and hands. On reaching Liverpool she had to be carried on board the steamer. The symptoms continued without intermission during the voyage to Dublin; she was then taken to the North Union Hospital.

Nov. 5th.—*Symptoms on Admission.*—Involuntary and tremulous motions of the arms and hands and fingers. The forearms and fingers are semiflexed, the muscles slightly rigid—it required some force to extend the fingers and the forearms. She cannot direct the hands to a given point, and is unable to grasp any substance; she walks unsteadily, and requires support. The involuntary muscular motions are confined to the upper extremities; no headach; pulse regular; tongue clean; appetite good; bowels free; complete immunity from pain or tenderness on pressure in any locality; catamenia absent for two months.

Treatment.—Put and kept under the influence of chloroform for ten minutes, during which time there was complete cessation of involuntary muscular movements; on recovering from the influence of chloroform the involuntary movements returned. Full diet was ordered, and the following pills prescribed:

℞. Ext. Belladonnæ,
Camphoræ, āā gr. vi.
Ext. Gentianæ gr. xii.
Capsici gr. ii.

M. et divide in pilulas vi. Sumat unam bis in die.

6th.—She has taken three pills since last report. The chloroform was again used with similar results. No amelioration of symptoms. Continue pills.

In the evening a splint was applied on each arm, extending from the tips of the fingers to midway between the elbow and shoulder joints; they kept the arms and fingers in the extended position.

7th.—On removing the splints this morning, there were no involuntary movements of arms or hands, and she was enabled, for the first time since the commencement of the disease, to take food and drink without assistance, and only complained of slight soreness of the lower third of the biceps muscles. The bowels not having been moved since the morning of the 6th, a turpentine enema was administered. The arms were rubbed with the following ointment:—

℞. Chloroformyli ʒi.
Ext: Belladonnæ ʒss.
Adipis præp: ℥iii. M. Ft. ungt.

The pills continued, and splints re-applied.

8th.—The bowels affected by enema; no choreic movements; can walk about the ward without assistance; slight debility complained of. Omit medicamenta, and splints.

9th and 10th.—Continues to improve; ordered the following mixture:—

℞. Quinæ disulph: gr. xii.
Inf: Rosæ ℥vss.
Tinct: cardam: c. ʒii.
Sumat chl: ii. ampla bis in die.

12th.—Convalescent; discharged from hospital at her own request.

Observations.—Chorea rarely occurs after puberty. During the last seven years we have had several thousand females over fifteen, in hospital, yet this is the first case that occurred. A. Fitzpatrick was not of a nervous temperament; she never had hysteria; there was no evidence of functional or organic lesion of the cerebral, thoracic, or abdominal organs to account for the invasion of the disease, if we except the absence of the catamenia for a few months. If derangement of the uterine functions produced chorea, our wards should never be exempt from it. We have never witnessed a case of uncomplicated chorea terminating in death. There are on record some ten or twelve cases that proved fatal.

The treatment adopted in this case proved efficacious in a very short time, the usual duration of the disease being from three or four weeks to as many months. We attribute the good effects principally to the use of the splints; they can be applied with equal facility to the lower extremities, when they are seized with choreic movements.

CASE OF A PIN EXTRACTED FROM THE LARYNX.

BY CHARLES C. DUIGAN, Esq.,

MULLINGAR.

All cases of foreign bodies in the larynx possess considerable interest. The present case is remarkable for the very short period which elapsed between the introduction of the pin and the possibility of discovering it externally.

On the 2nd of June, 1855, the wife of a railway labourer brought to me her child, aged six and a-half years of age, and gave the following history of its case:—Two days previous, whilst the child was playing, a pin slipt accidentally down its throat; feeling it to stick there, the child became greatly alarmed. The mother brought the child to a practitioner in her neighbourhood, who got it to eat some stirabout, and then administered an emetic, and, finally, took from the ejected contents of the stomach a pin, as though it were the one which had been swallowed; this little *ruse* was, no doubt, intended to lessen the fears of the mother. The child, however, persisted in declaring that the pin was still sticking in her windpipe; soon afterwards she complained of a prodding sensation in the larynx on attempting to swallow; a large morsel did not produce additional inconvenience; there was neither cough nor difficulty of breathing. On extending the neck a slight conical projection of the skin was discernible, corresponding to the crico-thyroid space, and to the left of the mesial line; the projection followed the movements of the larynx, and I supposed it to be the point of the pin which had passed through the walls of the larynx. In the presence of my friend, Dr. Kelly, I made an incision through the skin and adipose tissue; a small dark speck then presented itself covered by a thin layer of fascia, on dividing which I discovered the head of a brass pin just external to the larynx; I grasped it with a forceps, and without difficulty removed it. The pin lay horizontally, its point, which was slightly bent, being directed backwards and to the right side. The child quickly recovered.

PATHOLOGICAL SOCIETY OF DUBLIN.

The first Meeting of the Session, 1855-56, was held on Saturday, November 24th, when the following Officers for the ensuing year were elected:—

President.—Dr. Stokes.

Vice-Presidents.

Dr. Banks,
Dr. Corrigan,
Dr. Fleming,
Dr. Hutton,
Dr. Law,
Dr. O'Ferrall.

Council.

Dr. Adams,
Dr. Beatty,
Dr. Churchill,
Sir P. Crampton,
Dr. Gordon,
Dr. Hamilton,
Dr. Hughes,
Dr. Lees,
Sir H. Marsh,
Dr. Mayne,
Dr. M'Dowel,
Dr. Smith.

Treasurer and Secretary.—Dr. Smith.

Dr. Fleming exhibited a series of specimens illustrative of the pathology of superficial necrosis, and Professor Smith exhibited a specimen of gun-shot wound of the knee joint.

The particulars of these communications will be given in our next Number.

Bibliography.

Traitè des Fractures et des Luxations. Par J. F. Malgaigne, Professeur de Medecine Opératoire a la Faculté de Mèdecine de Paris; Chirurgien de l'Hôpital Saint-Louis; Officier de la Legion d'Honneur, &c. 2 vols., with an Atlas of Plates.

(*Continued from page* 317.)

7. *Dislocation backwards beneath the Acromion Process—(Luxation sous Acromiale).*—In this luxation the head of this bone is found beneath the posterior angle of the acromion process.

The accident is rare, and, according to Malgaigne, was first observed in 1804. He has met with three cases himself, and compared them with thirty-four cases published by others. It is especially rare in the female, and as to age, the same rule holds good as in the other luxations; of twenty-seven cases, nineteen were over forty years of age. In a large number of instances, the accident is produced by sudden muscular action, viz., in more than one-fourth. In seven instances, it was the result of epilepsy. Violent rotation of the arm inwards may produce it.

Symptoms.—In addition to flattening of the shoulder, as in the other luxations, the most striking symptom is the appearance, as if the shoulder were carried outwards, so that the chest looks larger (broader) on the injured side. The coracoid process and acromion are unnaturally prominent anteriorly, and a groove is seen to separate them. This is less evident in the very recent case. But at all events, the touch distinguishes them, and the finger can then be pressed down on the inner edge of the glenoid cavity. The axilla is free from any tumour. The head of the bone forms a remarkable prominence behind, swelling at first may mask it a little, but it can be felt rolling under the hand when the arm is rotated. The arm hangs by the side, and is rotated inwards. Measurement seems to give contradictory results.

These symptoms are pretty much the same as those given by other authors, but in the position of the luxated head of the bone, there is a diversity of opinion. Malgaigne says he has always found it beneath the posterior angle of the acromion. Velpeau, Goyrand, and others, say the same, but other surgeons assign the infra-spinal fossa as its position. Petit asserts this, although he never saw the luxation, and Boyer scrupulously follows him. The same is said by A. Cooper, on the authority of two cases which occurred whilst he was yet in his apprenticeship; one of those he saw, and the other was reduced by the "intern," and he never saw it.

According to Malgaigne, there are several degrees of the accident. In many cases it is *incomplete*, that is to say, that the head of the bone rides on the posterior glenoid edge: the luxation is *complete* when the neck of the humerus corresponds to the glenoid margin.

When left unreduced, this accident embarrasses greatly the motions of the arm; the hand cannot be carried to the head, and sometimes not even to the chin, and when the luxation is complete, the hand is kept in a state of pronation.

Of the *pathology* of this luxation but little is known; when the luxation is produced in the dead subject, by forcible rotation of the arm inwards, the capsule is found torn posteriorly, and what is very remarkable, the tendon of the subscapularis is detached from the lesser tuberosity.

Sir A. Cooper gives the dissection of a case after seven years, in which the luxation had been produced during an epileptic fit, very probably by forced rotation of the arm inwards; the tendon of the subscapularis was torn from its insertion; the humeral head, covered by the infra-spinatus and teres minor, rested on the outer border of the glenoid cavity, and was distinctly flattened at the point of contact. In a recent case dissected by M. Langier, the tendon of the subscapularis was likewise torn, as was the infra-spinatus: the head of the bone had passed between the infra-spinatus and the teres minor, and lay immediately beneath the deltoid. In one case of Malgaigne's, the luxation was complicated with a fracture of the great tuberosity.

Reduction was effected in one case by Sedillot, after one year and fifteen days; the resistance will be greater or less according as the displacement is more or less complete.

In one case, as Sir A. Cooper was elevating the arm to examine the joint, the head of the bone entered its cavity; the reduction was effected before the accident was recognized. A similar case is mentioned by Velpeau. These are exceptional occurrences. Malgaigne thinks that direct pressure with the thumbs on the head of the bone, with counter-pressure on the joint of the shoulder by the other fingers, should succeed in the majority of cases.

After reduction, the luxation is apt to recur. Boyer presumes that there is then an abnormal condition of the glenoid cavity.

8. *Dislocation into the Fossa Infra-Spinata.*—Here the head of the bone lies beneath the spine of the scapula, and behind the posterior angle of the acromion.

Malgaigne has only seen one example of it. A carter, æt. 62, was thrown down, and the wheel of a heavily-loaded *voiture* passed obliquely over the right side of his chest; frightful injuries resulted; the axilla was enormously distended, and tympanitic. Osseous crepitation showed the fracture of the ribs; the scapula also was broken; but, in addition, the acromion was prominent, and a depression existed beneath it, whilst the head of the humerus projected posteriorly a long way from the acromion. The patient died in thirty hours, and dissection showed a fracture of six ribs, and several fractures of the scapula. Several muscles were torn or bruised. The head of the humerus lay in the most external portion of the infra-spinal fossa, just below the spine, whilst the lesser tuberosity lay opposite the glenoid cavity.

Dislocations may be combined with other lesions. The following complications are fully entered into:—1. Detachment of the great tuberosity. 2. Fracture of the great tuberosity or of the head of the humerus. 3. Fracture of the anatomical neck. 4. Fracture of the glenoid cavity. Lastly, the combinations of dislocation with rupture of the axillary artery, with paralysis, with lesion of the integuments, and with injury of the inner wall of the chest, is entered into.

Reduction of Dislocations of the Shoulder Joint.—To effect this so many methods have been adopted that the description of them has been always confused, and the more so that most of them have been indiscriminately (*pêle-mêle*) applied to all forms of luxation.

Recent luxations generally yield to gentle means; *direct pressure* with the fingers in the axilla may suffice. Dessault combined counter-pressure on the acromion; the fingers of both hands being crossed in the axilla, he applied the thumbs against the acromion.

Again, in order to act on the head of the bone as on a lever, various means have been adopted to obtain a *point d'appui* for the upper end of the bone, whilst the elbow is pressed to the side. Lisfranc used to place his closed hand in the axilla; in 1833 D. Bell revived this method.

Ch. Bell used to place his fore-arm beneath the axilla, whilst with the other hand he quickly depressed the elbow. Other surgeons, as far back as the time of Hippocrates, have been in the habit of placing their shoulder beneath the axilla, and so raising the patient from the ground. All these plans are faulty, because, whilst endeavouring to push the humerus outwards, no attempt is made to fix the scapula. This is remedied to some extent in the method used by Gerard: the patient being seated on a chair, an assistant, standing at the uninjured side, places his arms round the patient's neck, and crosses his hands on the scapula, the surgeon, standing at the side of luxation, places his left arm as high up in the axilla as possible, and with his right hand brings the patient's arm close to his own side; extension is now made downwards and outwards, and according to Gerard, the luxation is reduced without using more than one-third of his available force. In fifteen years he states that he has thus reduced thirteen luxations. Cooper's method by the knee in the axilla, belongs to this class of proceedings.

To *disengage* the head of the humerus various means are adopted. These *procédes de dégagement* may be reduced to three—rotation inwards, rotation outwards, and direct elevation of the arm. Hippocrates has described the method by *rotation inwards*—the fore-arm being carried behind the back of the patient, the elbow is elevated with one hand and rotated, whilst the scapula is passed down with the other hand, so as to limit its movements. Notwithstanding the obvious *bizarrerie* of this proceeding, says Malgaigne, I must say that it was in accordance with the result of my own experience, and in the dead body the greater number of the subcoracoid luxations may be thus perfectly reduced, care being taken to elevate the arm to nearly a right angle with the trunk. In fact, this position relaxes the deltoid, biceps, supra and infra-spinati muscles, and the capsule, whilst the rotation inwards removes the tension of the subscapularis.

Syme was the first to use *rotation outwards*. "In recent cases," he says, "I have often reduced a luxation without any assistance. Placing one hand on the acromion, and then flexing the forearm, I suddenly draw back the elbow, and at the same moment rotate the limb outwards." The case of a countryman is also mentioned by him (Syme), who came with a dislocated shoulder. He told him to take off his coat; the coat was no sooner taken off, with a little assistance, than the man declared he was cured; the reduction was effected in the effort of taking his arm out of the sleeve.

Elevation of the arm was employed in the thirteenth century, by Brunus; in 1762, by Thompson, and afterwards by White. At a later period, Hey gave it the preference. However, even in recent luxations, it is often difficult to effect the reduction without having recourse to forcible methods. Extension is made in different directions:

Obliquely downwards, by A. Paré, Petit, &c.

Horizontal extension was employed by Boyer.

Vertical extension, by White, who used to suspend the patient by the wrist over a pulley—the weight of the body acting as the counter-extending force.

Malgaigne considers extension upwards—not vertically, but obliquely upwards and outwards, as in reality the most rational. Without assistance he has thus reduced a luxation of eighteen days' duration. White's method, he thinks, is quite too complicated. He thus more simply proceeds. A towel is fastened round the wrist; the two ends are brought over the top of a door, until the arm is properly elevated. Holding the towel, he then flexes his knees, and is himself suspended from the shoulder of the patient, in a kneeling position. (*Je fais flechir les genoux a mon malade, et je me suspends a son epaule m'agenouillant moi-meme.*) In this way the extension may, of course, be made, by three or four assistants.

The method by the heel in axilla, adopted by Sir A. Cooper, had been more or less in use from the time of Hippocrates. When more force is required, Sir A. Cooper applies a towel above the elbow, by which several assistants keep up the extending force, pressure by the heel in the axilla being still maintained. Malgaigne observes that the heel thus applied is injurious in two ways—by pressing the pectoral muscle upwards, which thus draws the humerus in the same direction; and secondly, by causing counter-pressure at the scapula to be neglected. Hippocrates has, happily, in this respect, found a better method. He placed a round ball in the axilla, on which the heel pressed without touching the muscles; over this a large soft strap was applied, the two ends of which were held by an assistant who sat opposite, and who, at the same time, pressed his foot down against the acromion, so as to keep up counter-pressure. By others, instead of the heel, a door, the back of a chair, a round bar, the rung of a ladder, &c., were made use of. Examples are mentioned of the injurious consequences of such means. Petit often saw deep-seated abscesses to be the result, and once knew the axillary artery to be thus ruptured. Delamotte has seen the upper epiphysis of the humerus broken off by such means.

With reference to the subcoracoid dislocation in particular, Malgaigne believes that extension obliquely upwards is the best suited. He would always use it at first, as even a luxation of long standing may be thus reduced. White thus reduced a luxation after three months. In old cases, the direction may be advantageously varied. Malgaigne prefers extension from the wrist, and employs the pulleys with a dynamometer which registers the degree of the extending force.

Malgaigne mentions instances of luxations of very long standing having been successfully reduced. He reduced one himself of five months and four days' duration; one of six months' duration was reduced by Roux; Hajani one of seven months; Smith, of Connecticut, one of seven months and a-half, and another even longer; both occurred in the same person, who was a female.

[This part of the subject is very fully given, and our extracts are necessarily but very brief and imperfect. Any one desirous of knowing the full history of the different modes of reducing luxations of the shoulder cannot do better than consult this portion of Malgaigne's work.—TRANSLATOR.]

SELECTIONS FROM BRITISH AND FOREIGN JOURNALS, &c., &c.

Case of Pericarditis, with Effusion, successfully treated by Tapping and Injection of Iodine. By F. A. ARAN, M.D., Physician to the Hôpital Saint Antoine, Paris.

The operation of paracentesis of the pericardium has been performed on several occasions, and a most interesting article on the subject appeared in the *Archives Générales de Médicine*, November, 1854, compiled by Trousseau and Lasegue, and was translated at length into the *Dublin Quarterly Journal*, May, 1855. In the present case, however (which we copy from the *Bulletin Therapeutique*, November 15), M. Aran states, that he has verified the prediction of Velpeau, when he included the pericardium among the serous membranes capable of being treated by injection of iodine.

The subject of the case was a young man, twenty-three years of age, a mechanic; although of very delicate constitution, he had never suffered from any severe illness, except a pleuritis of the left side, with extensive effusion, for which he was treated in hospital, and discharged in pretty good health, on the 25th of November last. About a month afterwards, he was attacked with pain between the third and fourth false ribs on the left side, accompanied with oppression and palpitation of the heart after any exertion. He passed the winter, however, without any severe attack, but about the middle of last July he was seized with fever, headache, pain in the loins, palpitation of the heart, dyspnœa, and above all, acute pain below the left nipple. On his admission into hospital, on the 27th of July, there was no doubt of the existence of pericarditis, with copious liquid effusion. The patient was in a state of very high fever, intense heat of skin, cephalalgia, ardent thirst, pulse 116. The local signs were still more characteristic; lancinating pains in the fourth and fifth intercostal spaces on the left side anteriorly, increased by pressure; pressure at the epigastrium was equally painful. The extent of præcordial dulness was greatly increased, upwards to the summit of the third rib, inwards to the junction of the ribs and cartilages on the right side, measuring vertically about twelve centimetres, and about fourteen centimetres transversely; the impulse of the heart was scarcely perceptible; the sounds were dull and distant.

The delicate constitution of the patient, and the time that had apparently elapsed since the chest first became the seat of disease, prevented any very active antiphlogistic treatment being adopted. He also had diarrhœa for the last eight days, and upon examining his lungs, there were sibilant rales audible, principally over the left side. He was then cupped, and calomel, in small doses, given internally, and, for the purpose of hastening salivation, mercurial frictions to the chest were prescribed. This treatment was quite ineffectual; in vain were large flying blisters placed over the pericardium. Not only the disease was not arrested, but the effusion increased every day, and with it the embarrassment of respiration and circulation. On the third day after his admission, the pulse became feeble, irregular, remitting, and very rapid; at one time there was a total discordance between the pulse and the sounds of the heart; the mercury was persevered in, in hopes of touching the gums. Upon the 7th of August, says M. Aran, I was told at my morning visit that the previous day and night had been spent miserably, the patient, in imminent dread of suffocation, had passed the night sitting up in bed. The respiration was forty, and the pulse was irregular, intermittent, and extremely feeble—120 in the minute. This obstructed state of the circulating and respiratory systems was explained by the physical signs; the dulness now extended four centimetres to the right of the sternum, measuring sixteen centimetres transversely, and twelve vertically. The sounds of the heart were inaudible inferiorly, there was no impulse, the liver was displaced downwards, and to the left side, and extended across the median line. What was to be done? Were we to continue the same means when their failure was certain? All antiphlogistic measures were forbidden by the state of the patient, yet something must be done for his immediate relief, as he would perish in a few hours. I determined to puncture the pericardium, but here new difficulties arose. I had to choose between three different ways of proceeding—first, that of Riolan, which consisted in penetrating the pericardium through the sternum, by trepanning that bone; or secondly, that of Larry, who passed a trocar from below upwards, from right to left, in the space between the xiphoid cartilage and the left false ribs, thus penetrating the inferior part of the pericardium; and thirdly, the proceeding wrongly attributed to Senac, which consisted in penetrating through the fourth or fifth intercostal space into the pericardium by means of a trocar. I determined upon this last, which had been successfully practised by M. Jobert, of Lamballe, in a case published two years ago by MM. Trousseau and Lasegue. I was not a little afraid, however, to make the puncture with an ordinary trocar; so, with a view of avoiding all risk, I substituted a capillary trocar, as I had before done, with advantage, in puncturing hydatid cysts of the liver. I was satisfied that, even should this pierce the walls of the heart, it would not be followed by an immediately fatal hæmorrhage into the pericardium; to avoid this serious accident, however, I took the following precautions:—The circumference of the pericardium was circumscribed by a series of concentric lines from different points of the chest, converging towards the heart, and obtained by percussion, and the extent of the dulness correctly mapped out; the extent of surface, also, over which the sounds of the heart were inaudible was also ascertained. Completely absent in the inferior part of the dulness, they reappeared, but indistinct and muffled, in the fourth intercostal space, internal to the nipple. A sufficient space was thus left, into which the trocar might be plunged from before, backwards, without danger of wounding the heart. For greater safety I chose the fifth intercostal space, two or three centimetres from the extreme limit of the dulness. I first incised the skin with a lancet, and then slowly forced in the trocar from without, inwards, and a little from below, upwards. When I withdrew the stylet for the first time, no liquid flowed; I soon, however, penetrated the pericardium, for a liquid began to flow through the canula in jets, putting an end to my doubts upon this point.

This operation was certainly performed in less time than it has taken to describe it. Yet only those who have performed this for the first time can understand the anxiety I underwent during the first instant, and the lively satisfaction and extreme relief I experienced when I saw the liquid escaping. We drew off, through the canula, about twenty-six ounces of transparent reddish serum; the fluid escaped at first *per saltum*, and then more slowly, the patient aiding its evacuation by his own efforts, in which he was encouraged to persevere by the great relief afforded. Percussion showed a great diminution of the dulness; in proportion as the fluid was drained off the sounds of the heart became more clear and defined, unaccompanied by frottement; the pulse became stronger, more regular, and less frequent, from 120 it fell to 96 in the minute. I might have remained content with this palliative operation, but encouraged by the success I had had in pleuritis, I determined to inject the cavity cautiously with an iodine injection, composed of distilled water and tincture of iodine—an ounce and a-half of each, with fifteen grains of iodide of potassium. The excessive sensibility of the pericardium has been urged as an objection to this operation; in the present instance, contrary to all expectation, the injection was not even felt. After allowing it to remain in the pericardium for some moments, I drew off the greater part of it, and then closed the wound with graduated compresses, and a bandage round the body. No untoward event followed this operation, but the fluid collected again, and in a short time the patient had lost nearly every advantage gained by the operation. The dyspnœa returned, the pulse became again rapid and irregular, and the dulness, so much decreased at first, increased again, especially transversely; the arching of the chest reappeared, and the sounds of the heart became indistinct. In fine, upon the 19th of August, twelve days after the first operation, I again punctured the pericardium through the fifth intercostal space, following the same rules as before. I now gave issue to about forty ounces of greenish fluid, highly albuminous, very like bile in colour; it flowed, as in the first operation, in jets at first, afterwards more slowly in a stream. The patient, relieved by the escape of the fluid, aided it by his efforts, which we were obliged to forbid, fearing the entrance of air into the pericardium. Some air, however, did enter, after the iodine injection, which this time was made stronger (viz., an ounce and a-half of distilled water, the same of tincture of iodine, and a drachm of iodide of potassium), and allowed to flow off again altogether. We were now able to detect that interesting sign of hydro-pneumo-pericardium, first described by Bricheteau, which consists in a gargouillement or chopping sound, analogous to that made by a pump working in a cavity filled with air and water.

The pericardial region became also, after the operation, distinctly tympanitic. The constitutional disturbance, after this operation, was even less than after the first, and the relief obtained was much more decided. After a few hours the gurgling sound (*bruit de gargouillement*) and tympanitis had disappeared; but the fluid began to collect again the same evening. Upon the 21st of August it had reached its utmost extension, upon the 22nd it was stationary, and upon the 23rd it began to diminish transversely, and from above downwards. Soon the sounds of the heart were to be heard at the apex, and upon the 28th the dulness did not transgress the median line inwards, the nipple outwards, and the third rib superiorly. In spite of this most favourable progress of the disease the patient was not yet out of danger; the chest affection, for which he had entered the hospital, did not remain stationary; as the state of the heart improved, the signs of pulmonary tubercle became more evident, chiefly in the left lung, in which we had originally observed signs of inflammation. Nor was this all—towards the end of September the ankles became œdematous, followed by infiltration of the scrotum and lower extremities. Thanks to his youth—thanks also, probably, to flying blisters, which were applied in great numbers over the chest, and vapour baths, the œdema had totally disappeared by the end of October. By degrees the thoracic symptoms abated, his strength and appetite returned, the respiration became free, and, excepting the cough, which persists chiefly at night, the patient would consider himself recovered from a disease which had brought him to the verge of the grave. I need hardly say, that the physical signs of pulmonary tubercle persist, although the general health is so greatly improved.

Dr. Pollock *on Consumption.*

[We copy from a late number of the *Lancet* the following report, from the Brompton Hospital, on the Physical Signs of Phthisis. It is compiled from an analysis of eighty cases under the care of Dr. Pollock, whom we can recollect, several years ago, during his pupilage in the Dublin Hospitals, to have been most assiduous in his study of the preliminary symptoms of this insidious disease; it was with great pleasure we announced, not long since, that Dr. Pollock had been almost unanimously elected assistant physician to the Brompton Hospital, where the immense opportunities which he enjoys for the study of disease will, we are confident, be turned to good account.]

These cases do not give the more advanced phenomena of incurable consumption, which we deem of less moment; but rather four or five of the earliest and most reliable signs of impending phthisical disease, and tubercular deposition in the first or curable stage. We find that we may have pectoriloquy but no cavity, rather the opposite condition, or that of induration, so that many alleged cures of advanced consumption have really been cures of something else—e. g., a solid lung, in some cases, giving resonance to the voice. If the patient has been ill only a very short period, and is sent to Brompton with pectoriloquy, as a sign of consumption, we may be almost certain that it is not consumption, but rather that peculiar consolidation of the lung, from pneumonia, in which Dr. Todd finds the external use of turpentine so valuable. Dulness of the percussion note, especially at the upper part of the lung, or unusual distinctness of the *expiratory* murmur, are always, however, very suspicious attendants on any case where we have reason to fear tubercles; while dry crepitus, roughness of inspiration, and tubular inspiration, are observable in only half the cases of unequivocal phthisis, in the first stage. These facts cannot be too often repeated, as patients come in great numbers to Brompton from all parts of England and Scotland, who have no consumption, while others are sent only to die of what had been a long time incurable.

There is some reason for believing, that in the use of turpentine externally in consolidated lungs, something is due to its action as a stimulant or vesicatory on the skin, and something also to its vapour, combined with that of the water of the hot stupes, being *inhaled* by the patient. A sort of inhaler for turpentine vapour is, in fact, now being exhibited in the Paris Exposition,—a kind of medication which it is stated has effected some most remarkable cures in France. At Brompton Hospital, also, inhalations of chloric ether with hyoscyamus, of chlorine and chloroform, and of iodine and creosote, are all tabulated in the hospital pharmacopœia, of which we may speak on a future occasion. It appears pretty clear, also, that oil of amber and chloroform, which, rubbed on the front of the chest, form almost a specific for hooping cough, act in the same way, by lessening the local excitability of the bronchial tubes, partly by inhalation.

The first stage of phthisis, and the changes in health leading to the development of the tubercular deposit, are of paramount interest, both as regards the pathology and treatment of the disease; and Dr. Pollock is directing his attention especially to the elucidation of the early conditions which influence and determine the formation of tubercle from the blood. That tuberculosis has a constitutional, and not a local, origin and import; that certain blood changes, especially in the constitution of fibrin, are undergone before the local symptoms appear; and that a *state of health*, which ought to a close observer to be sufficiently characteristic, manifestly precedes the signs of deposit in the lung—are the pathological assumptions on which these observations are grounded. The entire absence of satisfactory results in the researches of Louis, Laennec, Lombard, and others, as to the influence of sex, occupation, climate, and temperature, on the development of phthisis, sets us free from the necessity of aggregating tables of statistics on these subjects. The influence of destitution, respiration of impure air, of dwellings where the light of the sun scarcely enters, of the depressing passions, of food of bad quality, of the strong and weak habit of body, were not found by Louis to have the influence which he had expected. "Out of thirty phthisical patients," he says, "twelve had been badly nourished, eighteen had been well-fed, yet the disease occurred at almost identically the same period in both. This result afforded me no small surprise." Again he says, "Phthisis is prevalent in all countries, the hottest and the coldest." Again, "Delicacy and weakness of constitution have long been esteemed strong predispositions to phthisis; still there is just ground for questioning the accuracy of this opinion. An analysis of the cases observed showed that phthisis passed through its various stages as rapidly in strong as in weak individuals." And so of inflammations as exciting causes: "Two hundred of cases of pleurisy left behind no trace of disease. In seventy-two cases of phthisis, four had pneumonia years before." Catarrh has no relation to phthisis; an opinion endorsed by Laennec:—"Nothing proves that the severest and most prolonged catarrh tends to produce any other affection of the chest, if we except emphysema or dilated bronchi." We cannot say so much, however, of strumous pneumonia or puenmonia in strumous subjects. These and many other as striking facts recorded by our ablest pathologists, in sweeping away popular views of the origin of consumption, lead us to the conviction that tubercle is a blood disease associated with the most intimate vital changes, alterations of nutrition under depressed nervous influences; mal-assimilation in its secondary processes of organic matters in food; and, above all, mal-appropriation of the daily waste of the fibrous tissues, which each and all give rise to a product of low organization in the arteries, ready to be deposited in any organ whose structure and functions fit it for the reception of a matter of low vitality, and without intrinsic capacity for being raised to a higher place in animal life. Such a position is found in the capillaries, and especially in the loose pulmonary structure itself, designed for the oxydation and removal of the waste of fibrinous material from the system. Once here, the disease, which is properly a fibrinosis, has become individualized and tubercular, and has added a local to its general signification and character. To the study of this preceding state of health must be brought assiduous observation, and possibly new methods and increased powers. Meanwhile it is something gained to recognize the direction in which our pathology must advance. A careful analysis of the blood itself, or the various secretions and excretions, and some measure of the quantity of carbon (or sugar? carbon and water) given off by the pulmonary membrane, would vastly improve our pathological knowledge, and throw new light on this and on other morbid processes of a chronic character. We have the satisfaction to know Dr. Edward Smith is engaged on these points. Dr. Pollock believes that this preceding disorder of the blood is associated with various affections and with several opposite constitutions. The predominance of the arterial temperament as opposed to the venous, anæmia, the hæmorrhagic constitution, purpura, are amongst those which he has seen. The influence of chronic dyspepsia, as affecting the state of the blood, is also often noted. A large proportion of the out-patients at the hospital for consumption are suffering only from this cause, and present no physical signs whatever. Gastrodynia is very prevalent in these cases. The purely hysterical cases are here, as in other hospitals, abundant, but require careful examination. To facilitate a recognition of the blood disease existing previously to the deposit of tubercle, the earliest departure from a state of health is noted. There is reason to think that emaciation is the first of which proof is possible, the waste of tissue being here an evidence of impaired nutrition, and itself a progressive cause of the hyper-fibrination of the blood.

To facilitate a recognition of the deposit in the lung, when the disease has reached this stage, Dr. Pollock has constructed tables, which test the relative value of the well-known physical signs of solidification of the pulmonary structure. It may be remembered that we dwelt before on hæmoptysis and sign of tubercle. Every case presenting any one of the following ten signs is entered in a tabulated book, and the presence or absence of the others is indicated by a mark. These tables are capable of furnishing, on analysis, a variety of information, to which we may afterwards allude, as, for instance, the combination of signs which existed in each case. At present we give the results of eighty cases of the first stage of phthisis, in none of which was there any evidence of softening having taken place.

Analysis of the Physical Signs in Eighty Cases of the First Stage of Phthisis.

1. Dulness on percussion, . . .	in 73	cases.
2. Deficient respiratory murmur,	„ 62	„
3. Rough inspiration, ...	„ 43	„
4. Expiration prolonged, . . .	„ 42	„
5. Increased resonance of voice, .	„ 42	„
6. Mobility of walls of the chest manifestly impaired, . . .	„ 38	„
7. Manifest flattening of the walls of the chest in the subclavicular region, ...	„ 36	„
8. Tubular inspiration, ...	„ 31	„
9. Wavy or interrupted inspiration,	„ 15	„
10. Dry crepitus, ...	„ 13	„

There is here, then, accumulated evidence of the known facts that dulness of the percussion note, deficient respiratory murmur, a roughness on inspiration, the expiratory sound unusually prolonged, and increased resonance of the voice, are the five earliest and most frequent signs of solidification of the lung. They throw no light on the cause of the abnormal condition, but indicate with certainty a mechanical alteration in the pulmonary structure.

Guided by the above pathological indications, the treatment has been directed to remove this consolidation, and to improve nutrition in the largest sense, whether by furnishing a pabulum to the blood, or by improving the digestive tone. Cod-liver oil is freely given, and answers both these indications, an increase of weight most frequently evidencing its nutritive power, whilst it manifestly strengthens the primary digestive function. The use of iron in restoring the blood when deficient in red particles is well known; but there is reason to believe, from what we see at Brompton, that its indiscriminate employment may precipitate the blood changes which result in a deposit of tubercle. Prolonged courses of strong chalybeate drugs have been observed by Dr. Pollock to have this effect. The cases require selection, as there is no agent more capable of invigorating the blood in one of its essential constituents, when employed at the proper time.

The possibility of recovering from the state of health preceding the deposit of tubercle is beyond doubt, although the clearing up of the lung, when once its formation has taken place, is uncertain. We spoke before (*loco citato*) of the frequency with which healed or obsolescent tubercles are found after death in patients dying of various surgical and accidental diseases. That this cure, or at least the attainment of chronicity in the local disease, ***when the constitutional affection has ceased***, is of more frequent occurrence than is generally supposed may be almost asserted. On this point we must look for further information, when the state of health indicating a blood change has been more recognized and accurately studied. The requirements for a cure would seem to be that the original blood disorder and blood contamination should have ceased, and that the local disease should have been originally small in amount, and have become inactive, so that the sympathies dependent on mere irritation may be trifling or altogether at an end.

Treatment of Chorea by Blisters.

Dr. Max Simon, several years ago, called the attention of physicians to the treatment of chorea by blistering. Since then, in a sanitary official report, M. Vandesleben has recounted three cases of prompt and permanent cure by the employment of blisters applied upon the arm and neck. Dr. Jensis has also published cases of a cure obtained by the same means, and remarkable from the fact, that the convulsive movements first ceased in the limb where the blister was placed, and finally gave way before blisters placed upon the other limbs and on the neck. M. Delaharpe, physician in Louisberg, has, in his turn, published four favourable observations of this mode of treatment, and makes the following remarks upon the subject: "Chorea being almost always more intense upon one side than on the other, he chose the inferior extremity of the most affected side; for making the first application in the leg the blister was placed below the head of the fibula, and in the arm below the insertion of the deltoid—it was left on until the blister was raised. The first dressing produced ordinarily an increase of the choreic convulsions; but this did not continue, and upon the second or third day after the application the disordered movements were much mitigated, not only in the limb where the blister was applied, but in the others also. As soon as the first blister has ceased to suppurate another is applied—its curative effect is more marked than the first, for often all the spasms have ceased in seven or eight days of this treatment. When the chorea is intense, and of long standing, a third blister will be required; it should be placed upon the neck. This last application is above all necessary if the head be much affected. At the end of six or seven days the cure is in general completed—the chorea has disappeared—but in order to avoid a relapse it will be necessary to have recourse to general treatment." M. Delaharpe remarks, that in the cases of thin weakly children the action of the blisters is most beneficial. In the cases of stout, strong children, which, however, are rare, success is less certain. When the spasmodic movements have disappeared, cod liver oil, quinine, and iron are to be administered according to the indications.—*Bul. Gen. de Ther. and Gaz. des Hôp.*

Rupture of Umbilical Cord.

Examples of very short umbilical cord are sometimes met with, but a case we find related by M. Schaffer, of Moselle, is certainly rare, in which the cord was so short (ten millimetres) that it was ruptured during delivery, causing hæmorrhage and the death of the child. A woman, twenty-five years of age, healthy and well made, was seized with labour pains at six o'clock in the morning; when examined the os was thin and supple, dilated to the size of a shilling, the membrane protruding; the pains were energetic, but at long intervals. At ten o'clock the dilatation was almost complete, the membranes broke, and the head descended into the pelvis; here it remained in spite of the pains. It was then found, upon the doctor being sent for, that the head occupied the fourth position, the dilatation was complete, the pelvis well formed, and the external parts dilatable. After some time the doctor determined to employ the forceps and terminate the labour, as the head made no advance whatever. They were applied with care, but failed to overcome some resistance, which, however, after some time, suddenly ceased, and the head descended between the vulva; a strong pain soon delivered the head, with the face to the pubis, the rest of the body immediately followed. The child, a female, large and well formed, was very pale, and gave no signs of life, whilst its movements but a short time before were distinctly perceived. The cord was found torn off clean to the umbilicus; it was large and solid, its extremity presenting the remains of torn membrane. Every means were used in vain to reanimate the child; it was dead from loss of blood; the cord, which was never tied, did not furnish a single drop of blood. Upon turning to the mother she was found to be losing blood fast. No trace of a cord could be found, so the hand was introduced into the uterus and the placenta removed. When examined, it was found entire; but in the centre, where the cord should have been inserted, there existed a circular pit; the extremity of the cord which remained attached to the infant being applied to this, it was found it fit it exactly in size. Thus the cord could not have been more than ten millimetres in length.—*Gazette des Hôpitaux.*

Complete Absorption of the Head and Neck of the Femur and Fracture of the Shaft from slight Effort.

The patient was a woman, 50 years of age, who had been bedridden and paraplegic for the last twelve months. On the 1st of November, 1855, Dr. Lichtenberg, the Resident Medical Officer of the German Hospital, Dalston, being in the house of the patient, was apprised that the latter had, on raising herself in bed, heard a crack towards the upward third of the femur, and that fracture was suspected. On examination, an oblique fracture was easily detected, and the woman was conveyed to the hospital. The legs were found much atrophied, powerless, and twisted inwards; considerable reaction had taken place at the spot where the bone had given way, and much swelling was observed, though free handling of the part gave the patient no pain whatever. The limb was put into a starch bandage, the manipulations being rendered somewhat difficult by continual convulsive movements. Severe diarrhœa soon supervened, the apparatus was removed, and the poor woman sunk rapidly. On a *post-mortem* examination, the head and neck of the right femur (the former moving freely in the cotyloid cavity) were found almost completely absorbed; the cavity was deprived of most of its cartilage, and in it were found five or six pieces of cartilaginous substance tipped on one side with phosphate of lime, and varying from the size of a bean to that of a grape-seed. The fracture was very regularly oblique, the bone stripped of its periosteum, and seemingly necrosed.—*Medical Times and Gazette.*

DUBLIN: PUBLISHED BY W. B. KELLY,
8, GRAFTON-STREET.
LONDON: S. HIGHLEY, 32, FLEET-STREET.
EDINBURGH: MACLACHLAN & STEWART.
December 1, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.

SENT FREE BY POST.

Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 22.—Vol. II. DECEMBER 15, 1855. Price 5d.

Clinical Lecture on Foreign Bodies in the Œsophagus.

BY JOHN HAMILTON,

SURGEON TO THE RICHMOND HOSPITAL.

PART I.

Many diseases will be submitted to your treatment, on which you will have time to deliberate: affections of the joints, of the bones, tumours, chronic abscesses, and the like. Others in which you will have no such advantage, but be called on to act at once. Among these will be included the majority of accidents; and in no description of accident more so than in cases of foreign bodies arrested in the œsophagus and windpipe. A woman has just left the hospital well, in whom I had to push a piece of beef bone, stuck in the œsophagus, down into the stomach. Before reading the case, let me make a few general observations.

In practice you will find yourselves most commonly called on to treat cases, where foreign bodies stay in the œsophagus, and cause choking, under two different circumstances. First, where the bodies are small and sharp (the most frequent), such as pins, small bones of fish, sharp splinters of bones swallowed in hash or mince, &c. Secondly, where too large a morsel, either a hard body, as an apple, or any soft tough material, attempted to be swallowed, becomes wedged in the pharynx, and the patient can neither get it up nor down; a lump of beef-steak, a crust of bread, half-chewed, for instance. The last division is much the most serious. A large body, by its pressure and position, closes the glottis, and speedy death is the result.

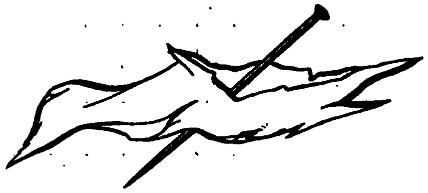
Now, as to the first, where a sharp piece of bone has stopped in the pharynx or œsophagus, two courses are open to you; to get it out, which is the most desirable, or to push it down into the stomach. Sometimes, though rarely, you will see the foreign body stuck across the upper part of the pharynx; this simplifies the extraction, but it is not always as easy as you might think. I recollect a young woman, who came to the hospital with a large pin wedged across the throat, the violent muscular efforts and contractions having served to force it in, and fix it at both ends. To disengage it I had to seize it in the middle, and push one end in deeper, till the other was loose. I was lucky enough to hit on the right or sharp extremity, and then withdrew it with ease. A woman had been eating fish, and one of the small bones stuck in her throat, causing excessive irritation, and sensations of choking and retching. I saw the end standing up at the left of the dorsum of the tongue, the other being fixed at the lower and posterior part of the tonsil. I readily seized it, but instead of coming easily away, I was astonished at the resistance, which required some force to overcome, as I had to tear it from its bed. When removed the reason was apparent; a small barb projected from one side of the end.

When you cannot see the foreign body, you may, if it is of any size, be able to feel it, and hence more accurately guide the forceps. In children this is more easy of course, from the shorter distance from the teeth to the pharynx. I recollect Sir Philip Crampton mentioning that he had in this way succeeded in detecting the position of, and removing a buckle which had stuck in a child's throat.

Generally you will be able neither to see nor feel it, but must trust to the evidence of the patient and his sufferings, as to the presence and situation of the foreign body in the œsophagus. Besides the miserable sensation of choking, and the indescribable distress exhibited by most people under these circumstances, they usually point, if the substance is sharp, to one side or other of the throat, as the seat of pricking pain. This is valuable information, and in trying to get it out should be borne in mind. The woman who has left the house pointed constantly to the right side, as the part where the bone was, and acting on this, I was successful in dislodging it. In attempting to dislodge a foreign body from the pharynx, you must be prepared for great difficulties, the chief of which are the spasmodic action of the muscles of the pharynx, the choking or sense of suffocation which the presence of your instrument causes, and that makes the patient instinctively put up his hand, seize and draw it out, before you have accomplished anything. In introducing your finger, let me caution you to guard it by a few turns of your handkerchief round it, or by an assistant holding the handle of a fork or something similar between the molars, otherwise severe bites are given by a sort of involuntary spasmodic closure of the jaws.

If it is a piece of bone of tolerable size, or a square bit of glass, not uncommon in children, or such like hard body, you may feel it with the œsophagus forceps, seize and withdraw it. Here are two kinds, one opening from before backwards, the other laterally, long, and of moderate curve. In passing them, keep well to the back of the pharynx, so as to avoid the glottis, and to the side the pain is complained of. If you catch hold of anything, you must be satisfied that it is no part of the edge of the glottis, but really the substance you are in search of. You will not, however, find the forceps a satisfactory instrument, and will be more successful generally with the probang, particularly as it is sold with two cords attached to it. You pass it carefully to the back of the pharynx, then tell the patient to swallow, when it will go readily down the œsophagus, unless stopped by the foreign body; a little force will usually get it beyond this, and when you are satisfied that it has passed it, the probang should be pulled up again, pressing as much as possible along the side of the pharynx where the patient points the substance to be. In this way I have removed many objects from the pharynx. Here is a very ugly bit of mutton bone, quite sharp at either end, and which stuck across the œsophagus. At the first attempt I disengaged one end, at the second it got entangled between the sponge and cords, and came out.

A young gentleman came to me in the evening with a chicken bone, he said, sticking in his throat, referring the place to the level of the lower part of the larynx. He could swallow water, but with pain; an attempt to swallow a crust of bread, which he had been advised by his friends to do, gave him great torture. I passed down the probang, not without some difficulty, below the seat of obstruction, and then drew it out, in doing which I felt slight resistance, but I was gratified to find that I had withdrawn the foreign substance entangled in the strings of the probang. On examination it proved to be not a piece of chicken bone, as he had thought, but a piece of the flesh of the chicken in a flake, an inch and a half long, transfixed by a pin. The point of the pin had luckily just entered the sponge, and remained fixed in it, as I drew the probang out. Poulterers, in sending home fowls, constantly pin paper round them; in this instance the paper had been torn off, and one of the pins still left in, and thus had been swallowed with the morsel of flesh through which it ran.



If you fail in your efforts to extract the foreign body, the next best thing is to get it into the stomach; it cannot be left in the throat where its presence is intolerable and dangerous, so with the round bit of sponge at the end of the probang you push it down the œsophagus into the stomach. But you will say, is there no danger in introducing into an organ, with thin membranous walls, such a sharp bit of bone as you have just shown us, or pins or needles, bits of glass, and such like? Well, there certainly is danger, but less than leaving the same substances in the throat. It is strange and interesting what hard and sharp things will pass along, through the pylorus, the whole tract of smaller intestines, by the apparently impassable ileocœcal valve, into the large intestines, and out by the anus. An apothecary in my neighbourhood came to me in great alarm with his little boy, about three years old, who had just swallowed an Irish diamond breast-pin. There was reason enough for the poor father's anxiety; as, if nature attempted to get rid of this long pin by the sharp end, transfixing the bowel and external parts, the large head would be an impediment to its progress, and hence be likely to cause fatal irritation. He was anxious to give castor oil. I objected to this, or to anything that would be likely to disturb the peristaltic action of the bowels. I desired the little boy to be let go about as usual, but that his food should be as solid as possible, as I thought the pin more likely to pass safely out of the stomach in a mass of chyme of some consistence. No real diamond seeker ever examined the mine with the same eagerness that the father did the first motion passed the next day by the little boy. He found the pin in it less than twenty-four hours after it had been swallowed. In this case no doubt the pin had fortunately gone with the heavy, blunt head foremost. If the foreign body is solid, and rather large, the pylorus sometimes refuses to let it pass, it causes uneasiness in the stomach, and is rejected by vomiting. Here is a large brass button, off the coat of one of the Dublin and Kingstown Railway servants. It was swallowed by a child four years old; caused uneasy sensations, and finally vomiting, by which it was happily rejected, without stopping in the throat. Generally, if of moderate size, even though sharp, as a pin or needle, the foreign body passes on, and is expelled through the anus. But if a sharp body, pushed into the stomach, is refused passage by the pylorus, and cannot be expelled by vomiting, it will try to get out through the walls of the stomach and abdomen. Many such cases are related by authors, where large pins, long, strong fish bones, even the steel with which butchers sharpen knives, have slipped down the œsophagus into the stomach, and made their way out through a large abscess pressing over them externally. In a few instances death has resulted. Schenkius relates that a large iron needle, which a man had swallowed, made its way out through the walls of the stomach, and then penetrated into the substance of the liver, and the patient died of tabes. Where the pylorus has been passed, the foreign body, if sharp, may be arrested in any part of the intestinal tract, and work a passage out by ulceration and suppuration at some part of the belly or groins, or even the loins. Pins have made their way into the bladder, and been passed with the urine, incrusted with calcareous matter, or have remained and produced the symptoms of calculus, and been removed by operation. In the *post mortem* examination of George the Fourth, how this takes place is shown. A sharp piece of mutton bone was found which had partly got into the bladder from the rectum, having transfixed the parietes of each, where they lie in contact, one end projecting into the rectum, the other in the bladder. A bit of bone has got safely to the rectum, pierced the bowel by the side of the anus, caused an abscess there, and so got out. Petit gives a case of this kind of a lady, in whom he removed, from an abscess by the side of the anus, a chicken bone. You will see, therefore, that in many, perhaps the majority of cases, foreign bodies, pushed from the œsophagus into the stomach, will pass on safely and without much disturbance; in others they get an exit by ulceration and suppuration at various parts of the intestinal tract, or of the body; the strange course of pins and needles being well known, even out through the testicles and scrotum. But in a few cases death has resulted from the irritation on their getting into a wrong track, as the liver or kidney.

Lectures on Diseases of the Stomach.

BY DR. LEES,

PHYSICIAN TO THE MEATH HOSPITAL, LECTURER ON PRACTICE OF MEDICINE.

No. IV.—*Passive Congestion; Chronic Gastritis—Anatomical Characters, Mamillation, Symptoms, Diagnosis, Treatment.*

I was near omitting to mention a very important sign which is often met with in sub-acute gastritis, namely, increased pulsation of the abdominal aorta, or its immediate vessels, which is symptomatic of inflammatory disease in the digestive system, analogous to the morbidly increased action of the radial artery in whitlow, or of the carotid or temporal arteries in cerebritis. It is often observed in gastro-enteric fever, and in peritonitis, when the want of proportion between the action of the radial and the abdominal arteries is often very striking; the pulse at the wrist being small and feeble, while the abdominal pulsations are comparatively violent. It may, however, occur, as a mere nervous condition, particularly in females, and also sometimes precedes the appearance of the menstrual discharge, when, if the patient be at the same time suffering from gastric fever, it might lead to a serious error in practice, which I was near committing in the case of a young lady, who, about the tenth day of gastric fever, complained of severe pain in the stomach, and on placing my hand there I detected violent throbbing of the aorta. I at first feared that it depended on an increase of the inflammation, and was going to order leeches to be applied, but as the other symptoms did not correspond, and it was near her menstrual period, I determined to wait, and was gratified the next day by finding that the increased pulsation had subsided, and the menstrual discharge had appeared.

Before commencing the subject of chronic gastritis, I wish to say a few words on *passive congestion* of the stomach, which consists in a morbid turgescence of the vessels of the mucous membrane, interferes with its proper functions, and often leads to chronic inflammation of that viscus. The causes of passive congestion are referrible to some obstruction to the onward course of the blood, or to an atonic state of the vessels, often owing to irregularities of diet, especially in chronic diseases, or in convalescence from acute diseases, and is mostly observed in the splenic region of the stomach. The muscular coat is generally much relaxed, and the congestion extends to the vessels in the sub-mucous tissue. Congestion from obstruction may be produced from impediments to the passage of the blood, either through the liver, the lungs, or the heart; but the effect on the stomach is the same in all cases—namely, congestion of its vessels. The "hob-nail," or whiskey liver, is the most frequent as well as the most important of these causes, for in this disease the current of the blood through the liver is impeded, and as the veins from the stomach and intestines send all their blood to the portal vein, they are consequently kept in a state of congestion, and an oozing of blood often takes place from the mucous membrane of the stomach, which, if in quantity, is vomited, but if small, is often passed off by the bowels, giving their contents a peculiar pitchy appearance; in some cases, however, the obstruction is thrown more on the subserous capillaries than on those of the mucous membrane, and thus ascites or effusion of the serum of the blood into the peritoneum occurs more frequently from this disease than the effusion of blood into the stomach.

In all these cases, when the vessels of the stomach are kept in a state of passive congestion from any impediment in the liver, heart, or lungs, the nutrition of the mucous membrane is less active than in health; the secretion of the gastric juice is diminished, and consequently digestion is slower and more feeble, so that if indigestible food, or more than the stomach can digest is taken, some of it remains undigested, irritates, and finally inflames the mucous membrane; the same effects take place from spirituous liquors or cordials, which are often resorted to by way of giving tone to the stomach in these cases. In the treatment of this condition always remember that the congestion is secondary, and will be relieved by lessening the impediment to the circulation on which it depends; but both food and physic must be regulated with reference to it. The diet should be spare, easily digestible, given at regular periods, and consist of solid rather than fluid substances; as broth, jellies, and such like, distend the stomach, and are more difficult of digestion than plain roast or boiled meat. Abstinence from fermented drinks is also advisable in such cases, if the patient's habits and nervous system can bear it; but if these rules are not attended to, the congestion of the stomach will be increased, and certainly terminate in an inflammatory condition of the mucous membrane.

Chronic gastritis is a frequent and very important form of disease, as it is not only often confounded with that mere functional derangement termed dyspepsia, but is often the result of the treatment for that affection. It may supervene on either acute or sub-acute gastritis, passive congestion, or be chronic from the commencement; but in most cases it is the result of a neglected sub-acute attack, aggravated by errors of diet, especially in persons of intemperate habits. Patients seldom die of this disease; but we have occasional opportunities of inspecting the stomach when they die of some other affection with which it co-existed. The mucous membrane is then found of a dark grey, or slate colour, caused by the action of the gastric acids on the blood, which, under habitual congestion, or slow inflammation, is detained in the vessels of the affected part; the mucous secretion is often much increased in quantity, and changed in quality, being thick and transparent, or ropy and viscid. The membrane itself may be indurated and thickened, or be pulpy, softened, and often thinner than natural. These various conditions are not necessarily a proof of actual inflammation, but rather indicate that a previous inflammation had existed.

The mucous membrane of the stomach often presents a very uneven surface, especially at the pyloric region, and about the great curvature, and offers, for a space of greater or less extent, elevations of a rounded or oblong figure, and from two to three lines in diameter, bearing some resemblance to the granulations on the surface of a healing ulcer, but not so prominent. This state is termed mamillated or *l'etat mamelonné*, and is generally considered as the result of inflammatory hypertrophy by Andral, Louis, Rokitansky and others; but Kolliker says it may occur in the healthy stomach; and Handfield Jones, one of the latest writers on the subject, considers that it is an "atrophic condition, the diseased part being thinned, not thickened; and that it is the shrinking in of this part which leaves the more healthy prominent, and forming mamillations." I believe there are two forms of this mamillation, one morbid, the result of a thickened chronically inflamed mucous membrane; the other, occurring in a healthy condition, and caused either by great contraction of the muscular coat, or by contraction of the fibro-cells which Kolliker has shewn to exist in the layer of mucous tissue, analogous to the corium of the skin. This state is certainly not necessarily connected with inflammation, for a similar appearance is produced by any cause which excites increased secretion in the stomach, as in those who die of malignant cholera, or of yellow fever—diseases in which there is an abundant secretion from the mucous membrane of the stomach; and this state has also been found as a consequence of retained secretion in healthy persons who have been killed when fasting; in all these cases the mamillated condition may be obliterated, and the membrane be at once rendered smooth and even by pressing out the fluid between the fingers. Dr. Budd considers that it depends on actual thickening of the mucous membrane at the projecting spots, and this appearance is most common in those parts of the stomach where the mucous membrane is thickest, and furnishes the most viscid mucus; so that it is chiefly met with about the pyloric orifice, and lesser curvature; but in the larger end of the stomach, where the mucous membrane is thinner, and its secretion more liquid, it is less frequently seen. We sometimes find a patch of variable size in the mucous membrane of the stomach, of a dull clear white aspect, which condition has been considered by Andral as the effect of chronic inflammation; for he states that he has always found it combined with other alterations, such as thickening and induration of the membrane. Handfield Jones considers it to depend on fatty degeneration of the epithelium of the tubes, and that it is akin to, and sometimes concurrent with, the fatty change in the liver. We may also include under the head of chronic gastritis, that condition termed by Rokitansky catarrhal inflammation of the stomach (or gastritis mucosa), which is generally chronic, and often a consequence of congestive disease of the portal system; the mucous membrane, in the pyloric and middle portion of the stomach, is congested, often ecchymosed, has a swollen œdematous appearance, and is covered with a thick tenacious layer of mucus, which Dr. Jones describes as composed of an "homogeneo-granular plasma, with free nuclei, and round or oval cells from the tubes, sometimes blood-globules, and imperfectly formed crystals of triple phosphate." This condition is often met with in disease of the heart, in pulmonary phthisis, in drunkards, in gourmands, and will help to explain the loss of appetite which these patients experience, as the effusion of this alkaline mucus must interfere seriously with the process of digestion, not merely by its rapid decomposition, thus acting as a ferment for the food, but also mechanically, and by diverting the gastric tubes from producing their proper digestive principle.

The *symptoms* of chronic gastritis in the early stage are often variable, obscure, and of such a character as to deceive the patient, for drowsiness and headache after meals may be the chief symptom, but in well marked cases there is acidity, flatulence, a sense of oppression and distention of the stomach after food, particularly of a solid kind, and there is often severe pain felt immediately on taking any kind of food, which may continue during the process of digestion or till vomiting takes place. Pain is very variable, both as to its seat and character; it is generally aggravated by warm drinks, and may be referred to the xiphoid cartilage, to the right or left hypochondrium, to the back, opposite the stomach, or even to the left shoulder; sometimes it is a dull heavy pain, or rather a sense of constriction at the epigastrium or behind the sternum, it may arise spontaneously, or only be caused by pressure, by the taking of food, or occur during the act of digestion. Some patients take a disgust to food, others dread it from the feeling of pain it excites.

There is seldom thirst except during digestion, and it is during this period that vomiting generally takes place of very sour, half-digested food, from which they experience great relief. In some cases, particularly in persons of intemperate habits, there occurs a profuse discharge of dark blood from the stomach, probably owing to a relaxed though congested state of the vessels. The tongue may be pale and flabby, coated with a white fur, or with thick viscid mucus, and indented with the teeth, or it may be smooth, glazed, and too clean, as if denuded of its epithelium, or it may be red and fissured, or covered with apthæ. The skin is often rough, dry, and subject to eruptions of urticaria, or papulæ, or scales. The circulation is tranquil, except during digestion, but there is often great emaciation. The urine may be high coloured and acid, with a copious deposit of lithates, or it may contain oxalate of lime, and then there is often frequent desire to void it; or it may be pale and alkaline, with a white deposit of phosphates, or an iridescent pellicle on its surface. The bowels are generally constipated, unless there be tubercular disease of the lungs (which is often found connected with it), when there is diarrhœa, and frequently an evening paroxysm of fever. The sympathetic disorders of the nervous system are numerous, evinced by headache, vertigo, muscæ volitantes, sleeplessness, irritability of temper, or despondency, apathy of mind and body, pains in the limbs, and hallucinations. They may suffer from dyspnœa, cough of a hard, resonant character, and even paroxysms of asthma, palpitations, pulsations in the epigastrium, with irregularity or intermissions in the pulse. Most of these symptoms, however, are met with in mere dyspepsia, also in specific diseases of the stomach, so that a correct diagnosis is often exceedingly difficult.

Two circumstances are of great importance in making a diagnosis; first, the length of time the disease has lasted; secondly, the result of treatment, for, if the disease has lasted a considerable time, and been aggravated by the ordinary treatment of dyspepsia, the great probability is, that the symptoms are caused either by a chronic inflammation of the gastric mucous membrane, or depend on some specific disease.

Chronic gastritis may be distinguished from cancer in this, that the former mostly supervenes on, and complicates some other disease, or is caused by intemperance, and errors of diet; secondly, that there are frequent bilious vomitings; thirdly, that vomiting occurs soon after food has been taken; fourthly, there are often pain and tenderness at the epigastrium from the commencement of the illness; fifthly, there is always more or less of fever during digestion; sixthly, there is no vomiting of stuff like coffee-grounds; seventhly, no tumour can be detected; eighthly, there is not the peculiar aspect that the victims of malignant disease present.

The causes of chronic gastritis are various, it often occurs secondary to tubercular phthisis, to disease of the heart, or the liver, and is often the most prominent feature in Bright's disease of the kidney, but it is generally caused by intemperance in eating and drinking. You should be aware, however, that it may also be caused by an opposite condition, as has been shown by Mr. Malcolmson, in a letter addressed, in 1837, to Sir Henry (now Lord) Hardinge, on the effects of solitary confinement, and a bread and water diet, on the health of prisoners in India. He says, "Many men, particularly those of indolent habits, endure a confinement of five or six weeks on bread and water without injury to their health, but in some instances a short period is *sufficient to cause a total loss of appetite, bread is hardly touched, and on other food being allowed, the patient is unable to eat or digest it*, there is constant uneasiness about the stomach, the liver is torpid, the bowels confined, or relaxed with slimy discharges; and the swollen red tongue indicates the existence of irritation of the mucous membrane of the digestive canal, the pulse becomes quick and feeble, while the clammy skin, vertigo, debility, headache, and sleeplessness show how much the constitution suffers from diminished nervous power; their convalesence is slow, and even the subsequent allowance of food, sufficient for the maintenance of health, often fails to restore him."

Chronic gastritis is generally a tedious disease, very liable to relapse, and though seldom fatal, "per se," yet it may cause death by inducing a state of general exhaustion, owing to the long-continued irritation of such an important organ, and its interference with the digestive and nutritive processes. Some authors consider that chronic gastritis may prove fatal by inducing the simple chronic ulcer, and so cause death by hæmorrhage or perforation, or that it may terminate in cancer; but I hope to convince you that they are wrong, neither of these diseases being a result of inflammation. It is certainly true, that a cancer may be excited in the stomach of a person predisposed to the disease, by an attack of inflammation, as we see to occur in the breast after an injury, but there must always exist a predisposition in the constitution.

Before commencing the treatment of chronic gastritis, always make a careful examination of the region of the stomach itself, and at various times, both when the stomach is full and when it is empty; ascertain if there be any tenderness, or induration, or tumour, do not begin by ordering what are popularly termed stomach medicines, or be content with merely prescribing for symptoms. If there be tenderness in the epigastric region, commence by applying four or six leeches every second or third day, for three or four times, so as not to exhaust the patient's strength before you reduce the morbid action in his stomach; allow him but a small quantity of food, and that of the mildest description, consisting of farinaceous articles and milk, order abstinence from all stimulants, from hot tea and coffee, not to distend the stomach, nor to take any active exercise; you must follow up this by counter-irritation, either with croton oil, or a succession of small blisters, or with the tartar emetic ointment, mixed with mercurial ointment. Regulate the bowels by enemata, put him under a mild course of mercury, which will keep up the function of the liver as well as at the same time exercising its specific effects in altering capillary action, and by combining anodynes you will not only allay pain, but correct that morbid sensibility, which often appears to keep up inflammatory action; so give three grains of mercury with chalk, and one of extract of hyosciamus or of lactucarium every night till the gums become tender. If there be much pain, give one or two drops of dilute hydrocyanic acid, with three grains of bicarbonate of soda in an ounce of distilled water, three or four times a day, or small doses of morphia, or dress the blistered surface with it. Do not push the antiphlogistic treatment too far, as the symptoms may be kept up by a state the very opposite to that of inflammation, and capable of relief by nutritious food and the judicious use of stimuli, for remember that in all inflammations there is a point where antiphlogistic treatment should cease and stimulants come in; so after a certain time you may have recourse to tonic medicines, and commence with the vegetable tonics, as chiretta, quassia, gentian, and if they agree, then you may try bismuth, the preparations of iron, quinine, but watch their effects, and stop them if they cause pain or sickness. There is one medicine which is often of great use in allaying pain and morbid irritability of the stomach; I allude to the nitrate of silver, and it appears to be peculiarly advantageous in these cases in which the tongue is shining and smooth, as if the papillæ had been shaved off. Make your patients wear flannel, use the warm bath occasionally, and take moderate exercise; regulate the diet carefully for a considerable time, even after they consider themselves as cured. If they can afford it, send them to some of the mineral springs, Leamington or Buxton, in England, or Ems, Weisbaden, or Vichy, on the Continent.

On Typhus Fever.

BY DR. GORDON,

ONE OF THE PHYSICIANS TO THE HARDWICKE FEVER HOSPITAL.

Subdivision of Typhus Fever into maculated and non-maculated; Case of Ague ending in non-maculated Typhus; Cardiac Murmur; fibrinous Concretion in right side of Heart; acute Emphysema of Lungs.

Hugh Reilly, a dairyman, ætat. 20, was admitted into the Hardwicke Fever Hospital on November 1st. He was at that time fourteen days ill; from the history which he gave of his illness, and the symptoms which then existed, he was evidently labouring under an attack of intermittent fever, although I could not trace the origin of the disease to any peculiar malaria. The fever assumed the rather unusual form of the quartan ague; there were two clear and distinct days on which there was no paroxysm; but when they did occur, they were unusually severe, and were always accompanied by very sensible splenic enlargement. He was treated at first, after mild but efficient purgation, with sulphate of quinine in moderate doses. This plan not succeeding, a large additional dose was administered a short time before the febrile accession was expected, and thus the disease was arrested—and that suddenly; it did not yield by the paroxysms becoming gradually less severe, or the intermissions or intervals becoming more distant. The paroxysms came on at noon—he had a severe attack at this hour on November 11th; he had another equally severe on November 14th, and this was the last. Although the attack of ague terminated, the patient did not appear to convalesce satisfactorily; on the contrary, the apparent immunity from disease which he enjoyed during the intermissions, now deserted him, and he gradually assumed the aspect of one labouring under typhus fever. His symptoms realyzed Fordyce's definition of fever, so often quoted—the whole system was affected. The cerebro-spinal system was engaged, for the patient suffered from pain in his head and back, weariness of his limbs, soreness of the entire body, restlessness and inability to remain long in any position: his intellect became dull, and he raved occasionally at night. The respiratory system was engaged, for he complained sometimes of cough and weight on his chest, and the existence of sonorous and sibilous râles indicated that there was at least some congestion of the bronchial mucous membrane. The gastro-intestinal mucous membrane was engaged, for his tongue was hard, and his lips, and mouth altogether, were gradually becoming parched and dry; he had lost all appetite for food, and even for drink, and the bowels ceased to act spontaneously. The principal evidences of the circulating system being engaged consisted in marked acceleration of the pulse, and its great debility, while the morbid pallor and coldness of the surface showed that the capillary circulation was not in a healthy condition. In the present instance, however, all parts of the system, for a time at least, *did* appear to be uniformly and equally affected. I could not assign any preponderance to any collection of symptoms, or say that any particular system was more deeply engaged than the remainder. The patient was not maculated, nor had he an eruption of any kind at any period of his fever; neither were there present any of the other evidences of increased fluidity of the blood; the urine was scanty, but there was no evidence of its being infiltrated with blood; the expectoration, which was trivial, was in no wise sanguineous; the surface of the body was not mottled, but unusually pale; and there was no evidence of any venous congestion, capillary or otherwise. The sounds of the heart were natural and perfectly distinct.

The symptoms of typhus fever continued to increase and accumulate; and on the 28th there was superadded a loud *bruit de soufflet* towards the base of the heart, but not exactly in the usual situation where aortic murmurs are heard, it was confined to this situation, and did not pass into the large vessels. There was in this case no previous history of cardiac disease, nor any symptom of it during his stay in hospital. I had little hesitation, therefore, in designating this murmur (first developed on the 28th), in the nomenclature of Dr. Stokes, as the "typhoid anæmic murmur," and I carried out the indication it afforded by ordering for the patient an additional quantity of wine and diffusible stimulants, and extensive and repeated counter-irritation over the præcordial region.

The abnormal murmur persisted on the following day, with symptoms of greatly increased prostration and debility; the physical signs of bronchial congestion became less evident, while the patient complained of increased dyspnœa and pain, which he referred to the epigastrium. This apparent anomaly was accounted for by the sudden supervention of extensive emphysema of both lungs, evidenced by the usual physical signs of increased resonance on percussion, and diminished intensity of respiratory murmur. He died rather suddenly on the morning of the 30th.

The *post mortem* examination showed excessive vascularity of the meninges and substance of the brain, with slight superficial softening chiefly of its inferior surfaces. The lungs exhibited a perfect example of intense vesicular emphysema; the muscular structure of the heart was healthy; the valvular apparatus was perfect. The left side of the heart was almost empty; the right ventricle contained a well formed fibrinous coagulum; it was exceedingly firm and strong; passed into the pulmonary artery and through several of its ramifications, from which it was drawn out in an extensively arborescent form. It was formed of concentric layers, was partially adherent to the sides of the vessels through which it passed, and terminated not very abruptly. The liver was slightly congested; the spleen was about the natural size; when incised it seemed to be of normal consistence; the capsule, which was slightly opaque, had a shrivelled appearance, particularly along the circumference, where was a fringe-like border, as if the parenchyma had receded somewhat from the edge of the capsule. The mucous membrane of the intestines was healthy, excepting some spots of very decided vascularity, corresponding to the situation of Peyer's glands in the vicinity of the ileo-cæcal valve.

While I hold the doctrine of the perfect distinction between typhus and typhoid fever, and consider that distinction to be of the greatest practical utility, I have also long thought that typhus fever ought to be subdivided into the *maculated* and *non-maculated* form. Typhus fever is a disease in which certain materials of the blood are, by certain circumstances, rendered liable to undergo definite changes; and this subdivision founded on the two great changes which take place.

In the maculated typhus fever we have always in the eruption proof of the excessive fluidity of the blood; we are unfortunately seldom without some additional proof, either in high-coloured and albuminous urine, or expectoration tinged with blood, or the more alarming epistaxes and intestinal hæmorrhages; in the non-maculated typhus, on the contrary, we have no evidence of excessive fluidity of the blood, but every sign of an increase in the quantity of fibrine. Modern pathology has completely set aside the idea so long entertained, that the amount of fibrine was a representative of the active state of the different vital processes, and that, therefore, its abundance was indicative of great vigour and strength. It would be out of place to attempt here any enumeration of the diseases or morbid conditions in which the fibrine has been found to be increased; let it suffice to say, that such a condition is found not merely in the different forms of rheumatic disease, in which we are so familiar with its increase, but also in other febrile ailments, such as erysipelas, scurvy,[*] &c., &c.; and knowing, from the researches of Andral, that loss of blood does not tend to diminish the relative proportion of fibrine, but to increase it, we conclude that an increase of fibrine may also take place when a deficient quantity of blood is formed: we have then a physiological subdivision of typhus fever into two classes, both being essentially a blood disease, —but in one class, the fibrine of the blood being in excess; in the other, the fibrine being exceedingly deficient: in other words, we have a maculated and a non-maculated form of typhus fever, and the condition of the blood constituting the essential difference between the two forms.

The case above detailed was one of non-maculated typhus. For the amount of information which we possess relative to the existence of a cardiac murmur in this disease, we are indebted principally, if not altogether, to Dr. Stokes. His observations are, that *a special form of inorganic murmur, very rare in typhus fever, is sometimes heard in the short intermissions of the relapsing fever or in the typhoid disease itself.* After several practical remarks on the subject, he concludes by asking—"*Is there a special nervous condition of the heart, or must this state be combined with some alteration of blood?*" In the case under consideration the murmur was caused by, and its first existence was coincident with, the formation of the polypus in the right ventricle of the heart; that this cause was competent to produce it is proved by a case exhibited to the Pathological Society by Dr. Stokes, some years ago, and which occurred in the practice of Mr. Rynd. The case is thus briefly detailed by Dr. Stokes.[†]

"A young man who had been previously in good health was attacked with the symptoms of malignant cholera. Within a very few hours after collapse had been established, a loud bellows murmur was discovered at the upper and middle sternal region. This continued up to the time of death; and on inspection a large coagulum was found in the left ventricle, stretching upwards and extending through the aortic orifice into the arch of the aorta. The valves of the heart and its walls were found perfectly healthy, so that there can be no reasonable doubt that the bellows murmur was of recent production, and was owing to the interference of this remarkable coagulum with the proper action of the aortic valves."

The same cause which produced the murmur in the left ventricle, in Mr. Rynd's case, was sufficient to produce it in the right ventricle in the case of Reilly. Cases of fibrinous deposit in the heart are not very uncommon; yet it would seem to be a *vexata quæstio* at which side of the heart the deposit most frequently is found.

Simon's well-known experiments gave him, as a uniform result that the arterial blood deposits its fibrin with the utmost readiness, the venous blood with the utmost reluctancy.[‡] These experiments, however, were all performed on animals in perfect health, and are not exactly to the point. Dr. Richardson made a communication to the Medical Society of London on the 5th of April last, on the subject of fibrinous concretions in the heart, in which he gave it as his experience, that "the right side of the heart was a more common locality for them than the left.* I have, on several occasions, seen these fibrinous concretions, in *post-mortem* examinations of patients who have died of non-maculated typhus fever, and they have almost invariably been at the right side of the heart; we have in this fact the reason why, when a murmur is produced, "its point of greatest intensity cannot be referred either to the aortic orifice, or to that portion of the chest where mitral murmurs are supposed to be most intense, but to a point midway between the sternum and left nipple,"† the fibrinous deposit in the right ventricle of the heart giving rise to the murmur which we accordingly find to be so rare in maculated typhus, and to have been principally observed in non-maculated fever. I may here refer to a similar case of polypus in the right ventricle of the heart, published by Dr. Corrigan, in the year 1845, which appears also to have occurred in a case of non-maculated typhus fever.‡

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[*] Becquerel and Rodier, Chimie Pathologique, p. 59.

[†] *Vide* Stokes on Diseases of Heart and Aorta, p. 124.

[‡] *See* Simon's General Pathology, page 56.

I do not infer that no other changes take place in the chemical composition of the blood in typhus fever than those I have alluded to, but these I consider to be so obvious that we can found on them a practical subdivision of typhus. The relative mortality in non-maculated typhus fever is greater than in the maculated. The tonic plan of treatment which answers so well in the ordinary maculated form, I have not found so successful in the other. In the present case, as soon as the type of fever developed itself, I used large doses of iodide of potassium, with wine, but without any good effect. It is to be remembered in the present case, that the fever commenced after a decided attack of ague, in which Becquerel and Rodier assert that the fibrine of the blood is almost always increased in quantity.

It remains to consider the nature of the attack of emphysema of the lungs. It clearly was not a simple coincidence; it was developed in the course of the fever, and was evidenced about twenty-four hours after the cardiac murmur was first discovered. Dr. Richardson, in the paper above referred to, mentions emphysema of the lungs as a common consequence of fibrinous concretions in the heart.

Drs. Paget and Kirkes, in the Medico-Chirurgical Transactions, detail cases of obstructed pulmonary artery, but do not, I think, enumerate emphysema among the consequent diseases.

It evidently occurs, however, in consequence of the great additional labour thrown on some portions of the lungs, from the blood being unable to circulate freely. The fibrinous deposit obstructs either totally or in part a certain portion of the pulmonary artery, leaving useless a corresponding portion of pulmonary structure—of course, there being no anastomosis in the main branches of the pulmonary artery. Great additional labour is thrown on the remainder of the pulmonary system sufficient to cause the disorganization in question. This carries out the theory of the production of emphysema of the lungs, as stated by that practical physiologist, Dr. Gairdner, that emphysema of the lungs is "a secondary mechanical lesion, dependent on some condition of the respiratory apparatus leading to partially diminished bulk of the pulmonary tissue, and consequently disturbing the balance of air in inspiration."

CASES OF INJURY AND DISEASE OF THE TONGUE, WITH REMARKS.

BY CHRISTOPHER FLEMING, M.D., M.R.I.A.,

SURGEON TO THE RICHMOND HOSPITAL.

CASE I.—*Lacerated Wound of the Tongue.*—Patrick Browne, aged 35, a dealer by trade, was admitted into hospital in October, 1854, with an oblique slit in the tongue, implicating its whole substance, and occupying its anterior and left portion to the extent of about an inch. It was produced by a blow under the chin when the tongue was protruded. Considerable hæmorrhage ensued, the divided surfaces were irregular; they had been approximated with a suture, and lay in tolerably fair apposition. Inflammatory symptoms, both general and local, set in; the latter were particularly distressing, from the attending tumefaction. Articulation was most painful; and even respiration, especially at night, was often disturbed from the profuse salivation attendant. On the fifth day the suture burst through the wound, its surfaces became sloughy and angry looking, and the inflammation was more diffused. The pain experienced was most acute, darting through the corresponding ear, and the whole side of the neck, and the lymphatic glands under the jaw, were also swollen and tender. On the eighth day considerable hæmorrhage supervened during the night, and great relief to his suffering ensued; the surface of the wound now assumed a healthy, granulating character, and the surrounding symptoms subsided. I contemplated the re-application of a suture, but hesitated, from the irritated condition of the patient and of the wound. He left hospital with a deep granulating indentation in the tongue, a triangular portion on the outside being appended by a neck, which looked very unseemly. At the end of three weeks he was, by a curious coincidence, re-admitted under my care for severe contusion of the shoulder, and although in this in-

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[*] *Vide* Medical Times and Gazette, N. S., vol. x. p. 396.

[†] *See* Stokes on Diseases of the Heart and Aorta, page 503-4.

[‡] Vide DUB. HOSP. GAZETTE, O. S., vol. ii. p. 129.

stance nothing was done, the pedunculated character of the separated slip of tongue had solved down so, that the cicatrized edges of the wound were almost continuous, and no appreciable deformity was visible. The treatment adopted throughout presented no peculiarity; when the inflammation was most active, the application of a leech to the tongue was speedily beneficial.

Case II. *Deepseated intra-muscular Abscess of the Tongue.*—John Carolan, aged 35, tailor, was admitted into hospital in October, 1854. For a week before his application he had painful deglutition; his illness commenced with rigor and ordinary fever; his suffering was considerable; he felt on many occasions as if he would choke; the quantity of saliva secreted was so great that it flowed from his mouth, and so obstructed his breathing at night that he could not lie down; sudden attacks of dyspnœa seized him when it accumulated at the back of the pharynx, and the efforts to expectorate it were most painful. His principal complaint was referred to the base of the tongue; the movements of the organ were distressing and limited; he could not protrude it, it felt too full for his mouth, and the gentlest pressure on its dorsum was intolerable. Below the chin a swelling made its appearance, which from day to day increased, and now projected considerably between the symphysis of the chin and the larynx; the integuments covering it were tense and œdematous, but not much discoloured. In the mesial line, on making firm pressure, there was a sensation of fluctuation communicated to the finger; and all around, to an extent which could be hardly grasped by the hand, there was very much of œdematous tumefaction and dense hardness; the accent of the man was guttural, but the voice was tolerably perfect. His general appearance indicated much distress; his countenance was pallid and anxious, and very much of a low, irritative fever was present. On getting him to take some fluid the act of deglutition was obviously most painful, and most difficult, and required most studied movement to prevent paroxysmal coughing. I made a long and free incision in the central and thinner portion of the swelling alluded to, and a large quantity of purulent matter (free from fœtor) escaped. Under the free exhibition of stimulants, and suitable nutriment, and local treatment, improvement rapidly took place, and the man left the hospital at the end of a week, the wound being far advanced towards cure.

Case III. *Deep ulcerated Clefts in the Tongue.*—John Scully, aged 33, a butcher's assistant, was admitted into hospital in October, 1854, with deep ulceration of the tongue.

He had been a patient under my care about two years previous with retention of urine, attendant on stricture at the orifice of the urethra, the result of phagedenic ulceration of the glans. His countenance and aspect were strumous, and accompanied with opacity of each cornea. His complaint, on admission, was confined to the condition of his tongue. He stated that six months back, after exposure to wet and hardship, he first perceived a chink or fissure on the dorsum of the tongue towards its left side. This gradually extended, and ultimately the right side became similarly affected. In the interim he had no surgical or medical treatment. He did not feel acute pain from those fissures, except in swallowing hot or cold drinks, but mastication was often uncomfortable, and at night he suffered from the large discharge of saliva present. He considered his general health as being and having been pretty good. He had not been addicted to drink, neither had he any fresh syphilitic attack.

On examining the tongue, its dorsum was furrowed with two deep sinuous ulcerations, almost parallel to each other, the extent of which towards the base can only be seen by considerable traction forward of the apex, the voluntary protrusion of the organ being comparatively limited. Towards the base these sulci all but joined each other. Their depth was not less than three-fourths of an inch, and their length somewhat more than an inch. Their surfaces were covered with an orange-coloured tenacious matter, their edges were sharp, abrupt, and in some portions undermined. The body of the tongue was full, and its under surface of a dark congested appearance. The mouth was filled with saliva, and there was no fœtor worth noticing.

This affection of the tongue was solitary—no other symptom could be discovered which was not identified with the general temperament of the man. He was not much emaciated. He had no articular or other pains—no eruption—no marks of cicatrices of former cutaneous diseases of syphilitic taint. What preparation of mercury, or what amount of that specific he might have taken for the venereal attack noted, he could not state, but it was evident, from the mutilated condition of the penis, that the original character of the disease was more or less phagedenic.

At the expiration of a month after the admission of this man into hospital, he left with the ulcers of the tongue perfectly healed, and with obvious improvement in his general health. The local treatment adopted was the application of nitrate of copper to the ulcerated surfaces, its repetition being directed according to the condition of the ulcers and the substitution of weak lotions of it, or the "oxymel cupri subacetatis," as the curative stages advanced. The general treatment, in the earlier stages, consisted in the exhibition of chlorate of potash in gradually increased doses, from five to ten or fifteen grains, in combination with bark and sarsaparilla. In the after stages iodide of potash and iodide of iron were given in conjunction with the same medicine, and occasionally with cicuta.

I have repeatedly seen this man since his discharge from hospital. He continues at his former occupation, is free from any return of his complaint, and the tongue, though contracted and pursed up at its base, appears to answers all useful purposes, and to give him no annoyance whatever.

There is an excellent drawing, by Mr. Conolly, showing, on the same chart, the appearance of the ulcers of the tongue on his admission into hospital, and that presented when those ulcers were healed.

Remarks.—In the tenth volume of "The Dublin Quarterly Journal of Medical Science," I made a communication on diseases of the tongue, in which the respective subjects comprised under the headings of the above cases, were considered—namely, glossitis idiopathic and traumatic, deep-seated intra-muscular suppuration in the tongue, and ulcers of the tongue apart from those which are syphilitic or cancerous in their nature. The present cases are noted with a view to confirm my opinions therein advanced, and to direct attention to a subject of vast practical importance. The questionable propriety of the use of sutures in special wounds of the tongue suggests itself. Doubtless they are occasionally indispensable. Thus I have seen a case where, from the blow of a stool, a woman's lower lip and tongue were split through—the latter being rent in the mesial line to half its length—and here two points of interrupted suture were invaluable; but when those wounds involve the sides of the tongue, and that any contusion accompanies them, it appears a matter for consideration whether, as in Case I., they may not be safely dispensed with. Nature models those injuries very satisfactorily. Since the date of my communication, in 1850, I have seen five or six most urgent cases of the character noted in Case II. Call them by what name we please, abscesses of the tongue, or abscesses, or suppurative inflammation in the tongue, they demand the promptest interference.

Some time after I was suddenly called on to open the trachea in a case of the most extreme dyspnœa and dysphagia. Death was impending. I found all the characteristic marks of this sublingual, or intra-muscular suppuration. A free and deep incision, as in the case now detailed, gave instant relief, and rapid recovery took place.

The practical lesson we learn from the third case cannot be exaggerated; its details dispense with the necessity of any comment; but the use of the chlorate of potash deserves trial in cases of a similar nature; in this it was most beneficial. Respecting the use of this medicine, I may remark, that I know of none more likely to give satisfactory relief in the treatment of those equivocal ulcerations which occur at the back of the pharynx or in its vicinity, identified with which I viewed the ulcer in Scully's case. Iodine and its preparation with potash and iron may be of use, but the essential improvement first manifests itself whilst the chlorate of potash is being exhibited. Many most aggravated cases have passed through hospital, where its effects were most gratifying. Of course, I allude not to ulceration of the tongue—such cases are very rare, indeed. The following extract from the passage I have alluded to, respecting the application of nitrate of copper, may, perhaps, not be inapposite:—

"I have tried many local applications, and amongst others, the acid nitrate of mercury, but I have found none equal to the nitrate of copper. It is most invaluable as an application to this class of ulcer; and I may remark, that it will be found equally so in many of those small excavated ulcers of a semi-phagedenic character, which occur on the genital organs both of the male and female. It is a very deliquescent salt, and can be applied only in the liquid state. The surface of the ulcer should be well dried before it is applied, and afterwards covered with oil; and it should be borne in mind, as regards the tongue, that the superficial appearance of the ulcerated surface is often most deceptive, as the disease burrows very deeply. The best mode of fixing the tongue, for the purpose of applying the caustic, is by means of the fingers and thumb, a portion of lint, linen, or a towel being interposed, so that it cannot slip; and the best instrument for the application is a small piece of cedar, as prepared for paint brushes, the ends of which may be covered with lint or French wadding, one end being dipped in the nitrate of copper, the other in the oil, whereby no delay or confusion can ensue."

PATHOLOGICAL SOCIETY OF DUBLIN.

First Meeting, November 24, 1855.

THE PRESIDENT, MR. ADAMS, IN THE CHAIR.

Injuries of Bone.

DR. FLEMING presented some specimens illustrating the effects of injury to bone, and noted the importance of a knowledge of their pathology as preparing the surgeon for the result of those injuries, and as deciding him in the adoption or rejection of operative proceedings in their curative stages.

The specimens exhibited might be considered as the product of injury to the periosteum, terminating in necrosis, superficial or deep-seated. Such application of the term necrosis, Dr. Fleming remarked, was now somewhat sanctioned by *modern* pathologists.

Periostitis of Femur—Hypertrophy of Shaft.

The first specimen he would direct attention to was a wet preparation. It was that of a femur, roughened on its surface throughout, from the neck above to the condyles below, in the more advanced stages, the knee joint having been implicated. The periosteum was much thickened, and on making a longitudinal section of the bone, that appearance of hypertrophy of the shaft described by Lobstein as "Osteo-sclerosis," was well shown. The subject of the disease was a pensioner aged thirty-nine. He had been a gunner in the artillery, and had served his full time of twenty-one years. He had been in foreign service, in Canada, and in the Mediterranean, twelve or fourteen years, and whilst there had attacks of dysentery and of ague. The symptoms of periostitis had supervened after his discharge, were not attributable to any special cause, and progressed insidiously until August last, when he applied to Dr. Fleming with two long sinuses leading to the upper third of the femur, accompanied with obvious thickening of the periosteum and enlargement of the lower portion of the shaft of the bone. Progression became painful to him, and he was obliged to remain more or less in the recumbent posture. The integuments along the tract of the sinuses were not discoloured, but were œdematous and puffy. Under these circumstances he was admitted into hospital. On introducing a probe into the upper sinus, it passed a considerable distance towards the external and back part of the femur, near the insertion of the glutæus maximus muscle, and here the probe struck against a foreign substance, which was moveable under it; the lower sinus was about a hand's breath below the knee joint on the outside, and was distinctly superficial in its course, and without connexion with the joint. On introducing a piece of prepared sponge into the upper sinus, it was distended so as to allow the passage of a dressing forceps, when a piece of bone about one inch and a-half by three-quarters, was removed. This was porous and irregular throughout, as now presented. Nothing could have been more favourable than the progress of the case afterwards. The upper sinus completely healed, and the discharge from the bone diminished, when without any assignable cause a paroxysm of fever was ushered in, and fresh inflammation seized the lower portion of the femur. Notwithstanding treatment, this progressed, effusion took place into the bursa, under the extensor tendons; the knee joint became involved, and suppuration set up. Repeated accessions of fever, and repeated inflammatory attacks occurred; the limb became œdematous; the constitution gave way; signs of general dropsy presented themselves, and the man sank, emaciated, in the last week of October. At one time the removal of the limb at the upper third of the thigh had been contemplated, but was contra-indicated by the general symptoms notified.

The thickened periosteum, the roughened surface of the bone throughout, the solidified and hypertrophied shaft, even to almost complete obliteration of the medullary canal, were well marked, and the extension of the inflammation and suppuration, in the subsequent stages of the attack, to the complete destruction of the cartilages and ligaments of the knee joints, were equally obvious. The occupation of this man as a gunner in the artillery, and the supervention of the disease (ostensibly at least) after his discharge, were peculiar features in this case, apart from the condition of the bone, as regarded the propriety of amputation of the limb.

Exfoliation of Portion of Tibia and of Patella.

The second specimen exhibited was a thick and long portion of the fore-part of the tibia, including the tubercle which exfoliated after the lapse of nine months, subsequent to a severe burn from slacked lime, whereby the integuments were destroyed and the periosteum bared. A portion of the patella, in the same case, about the size of a shilling, was also shown, and the rare occurrence of such exfoliation alluded to.

Necrosis of Shaft of Fibula—Reproduction perfect.

This very rare form of necrosis occurred in a boy aged eleven years. He presented himself to Dr. Fleming, about three months after an injury, which was stated by his mother to have been a fracture of the lower end of the fibula, for which he was treated in hospital for four or five weeks. He was brought, on this occasion, to the Netterville Institution, was able to walk there, and on examination, the integuments along the outside of the leg were found thickened and œdematous. This was especially so along the line of the fibula; pressure here gave much pain. A small sinus was found about an inch or so from the external malleolus, which led to a bare and loosened bone. On enlarging the sinus, and seizing the bone with a forceps, the whole shaft of the fibula was easily removed. An outward case of new bone enveloped it, no hæmorrhage of consequence occurred, and recovery was rapid.

Mr. Stanley, in his valuable work on "Diseases of the Bones," in referring to some of the least frequent examples of reproduction of bone consequent on necrosis, notes—"Necrosis of the shaft of the fibula—reproduction of it perfect. —Museum Bartholomew Hospital."

Fracture of the Tibia.

Professor R. W. Smith exhibited the upper extremity of a tibia, which had been shattered by a ball fired from a minie rifle: it entered close to the tubercle of the bone; one line of fracture extended obliquely upwards and outwards into the knee joint, detaching the whole of the outer half of the articular surface. The wound was received on the 5th of November, 1854, at the battle of Inkerman; in the evening the patient was placed on board the Colombo, one of Her Majesty's vessels; he was much exhausted by the tedious and painful journey from the front; the time of the medical officers was so occupied in locating the wounded, that he was only ordered a full anodyne that night; upon the following morning the limb was amputated above the knee, by the flap operation, the patient having been placed under the influence of chloroform; the leg had become purple and swollen to nearly twice its natural size, in the short interval which intervened between the receipt of the wound and performance of the operation. The patient died soon afterwards.

Professor Smith having made some practical observations upon the dangerous nature of fractures extending into the knee joint, remarked that an additional interest attached to the specimen, from the fact of the patient in this case having been the Russian Major who obtained so unenviable a notoriety by his barbarous treatment of the wounded English lying on the field of battle, and read the following passage from the letter of the correspondent of the *Times*, dated November 8. "Russian officers were seen passing their swords through the bodies of our men, as they writhed in agony on the ground, and pointing to their men to bayonet them as they passed. Such are the armies of the Czar! A Major of the ruffian soldiery who perpetrated these deeds is, however, in our hands." Professor Smith, in conclusion, stated, that for the specimen he was indebted to the kindness of the surgeon who removed the limb, and who had been formerly one of his pupils.

The remainder of the time was occupied with the private business of the Society.

December 1, 1855.

THE PRESIDENT, DR. STOKES, IN THE CHAIR.

Caries, and complete Removal of the Petrous Portion of the Temporal Bone.

DR. BIGGER said that two cases of entire removal of the petrous portion of the temporal bone having occurred in his practice, he felt justified in registering the facts through the medium of the Society. A third case, of a nearly similar nature, had occurred in the practice of Sir Philip Crampton, and had also been presented to the Society many years ago. The observation of such facts is peculiarly valuable to subsequent practice.

CASE I.—James Dignum, five years of age, was brought to me on the 2nd January, 1849, suffering from profuse otorrhœa, of a most fetid character, from the left ear: the right ear was sound. The fetor was that characteristic of diseased bone, and was unlike the aromatic odour which proceeds from discharges from the internal ear when the membrana tympani has been injured, and which is so well known to those accustomed to treat aural diseases. The mother of the child stated that the disease commenced by an attack of pain in the ear about eighteen months previously, and that this discharge commenced very shortly after, when the excessive pain ceased; that it had been treated by various practitioners without effect, and that caustic and blisters had been the principal means employed.

On clearing away the matter with a small glass syringe with a crooked jet, something sharp was found protruding into the meatus. The first impression was that some foreign body had been introduced into the ear, but on further examination it proved clearly to be bone, and the fœtor excited the idea that it must be some bone entering into the structure of the internal ear. Seized with a forceps it felt slightly loose, but as it could not be dislodged without using force, and not knowing what bone it was, it was left for fourteen days longer, during which period warm water injections, and poultices of bread and water, with powdered charcoal, were used.

On the 16th January, 1849, the bone yielded to very slight traction, and was drawn out easily and without hæmorrhage. It was about an inch in length; one end terminated in two prominences, not unlike the open beak of a bird; this was evidently the remains of the carotid canal, the internal wall of which had been completely absorbed, so as to permit the exit of the bone without injury to the artery; close to this was the internal meatus; the meatus externus was situated about one-third from the end of the bone on one side, and both it and the other cavities were full of cerumen. The surface of the entire bone was abraded and rough, as if the hard crust had been filed off, and the entire bone was more porous than in the normal state, but yet very hard. No bad effects resulted from the removal, and the poultices were continued till the 14th of February, when suppuration had nearly ceased, and the ear only exuded a little clear serum. On the 1st of March the child was perfectly well, and the ear externally quite normal: the internal meatus was narrowed, and gradually decreased until it ended in a fine point.

The pulsation of the carotids was equal on both sides, nor was there anything remarkable to be noticed in the jugulars. There was no paralysis in any of the muscles to which the portio dura of the seventh pair of nerves is distributed. It is hardly necessary to say that there was permanent deafness.

A month subsequent this child had a sharp attack of scarlatina, succeeded by cellular dropsy in the face and limbs, from which it recovered under the use of bark and wine.

On the 16th May the child was last examined. He was then in perfect health; the ear was quite free from pain, and were it not for a slight serous discharge, perfectly well. The funnel-shaped cavity has become somewhat smaller. No cerumen.

CASE II.—Thomas Dowd, æt. 5, a strong, fat, yet strumous-looking child, the son of a mechanic, whose means were sufficient for every comfort, was brought to me on the 4th June, 1855, suffering from profuse otorrhœa of both ears. His cheeks bore marks of lunar caustic having been plentifully used, as they were blackened and blistered where it had overflowed with the fœtid discharge.

The parents stated that the child had always been healthy and strong, with an inordinate appetite, and that the only thing which had ever ailed him had been, occasional swelling of the glands of the neck, and some stiffness in the motions of the head, neither of which symptoms were constant. The running from the ears was first noticed in the summer of 1853, after a railroad journey, with some exposure, which caused inflammation and great pain in the ears, particularly the left, on the subsidence of which, matter began to flow from it, and shortly afterwards from the other. This matter had not at first the horribly fetid smell which it lately exhaled. An English general practitioner treated the child, for the first six months, principally by syringing and blistering; he was then brought to Dublin and treated by an aurist, with constant applications of lunar caustic to the ears, and cod liver oil internally; but not getting any better, regular advice was discontinued until the 2nd of June, 1855, when a gush of blood from the left ear frightened the family. The child was immediately carried to the nearest apothecary's shop, who poured fluid caustic into the ear, and inserted a plug, recommending them to bring the child to me in the morning. On the 4th June the child was brought to me. I carefully removed the plug, which, although it had checked the hæmorrhage, was not sufficient to restrain the discharge; there was no appearance of blood about the ear, but the smell from the copious discharge was almost insupportable. From this peculiar smell I suspected diseased bone, and on clearing out the ear, I felt denuded bone a very short distance from the meatus externus. The child's uneasiness and suffering prevented me from ascertaining whether it were loose or not, nor was I very anxious to interfere with it, through apprehension of again bringing on hæmorrhage. I ordered digitalis to be administered in small doses, placed a small plug of matico leaves in the orifice, and directed that linseed meal poultices and charcoal powder, in equal parts, should be applied.

June 12.—Suppuration profuse. No further hæmorrhage. Fetor decreased by the charcoal, but still indicative of caries. Having gained the confidence of the child by gentle treatment, I was enabled to feel that the bone was loose. I was afraid to remove it, suspecting that it might be a similar case to that of Dignum, and impressed with anxiety about its deep vascular relations. The same palliative treatment was pursued until the 24th of June, when a point of bone showed itself near the external meatus, and was drawn out gently without any hæmorrhage.

The right ear, meanwhile, was pursuing the same course which had been run by its fellow; suppurating very freely, but without the occurrence of hæmorrhage; and the mildest treatment being employed until the bone protruded, it was easily removed from its purulent bath by the aid of a forceps and gentle traction, on the 19th August, 1855, without either pain or hæmorrhage.

The course of this case has been favourable from the period of the removal of the bones; all suppuration shortly ceased; a little glycerine was dropped in from time to time, and occasionally the openings were washed out with a solution of Bewley's iron alum, gr. x. ad ℥i.

On the 14th September, I closely examined the child. The ears were normal externally; a slight watery discharge, free from smell, is emitted; the apertures in both ears end half an inch from the external opening, by contracting into a fine funnel a little flattened from side to side.

25th September.—No apparent ailment but deafness. Dr. Bigger then exhibited the bones which he had removed, and contrasted them with the healthy bone taken from a child of the same age. He said, no doubt could be entertained, notwithstanding the absorptive erosion of their surfaces, that they were petrous bones, and the same peculiarity was observable in both, that the portion of bone internal to the carotid canal had been absorbed, so as to prevent injury to the vessel when the diseased bone was removed. A large quantity of hard cerumen filled all the cavities. The great anatomical difficulty to be solved in those cases is the absence of paralysis in any of the muscles supplied by the *portio dura* of the seventh pair of nerves, as the internal auditory foramen was perfect in all the morbid specimens, and the parts through which the fallopian canal wound its course were hard and uninjured; so much so, that it would have been impossible for the nerve, if following its ordinary course, to have escaped from the bone, as it was evident the carotid artery had done.

The wonderful provisions of nature in thus separating one of the hardest bones of the body from its deep and important connexions with large sinuses, a great artery, most important nerves, and a very close proximity to the brain itself, are powerfully illustrated in these cases; as is also the value of an expectant practice in treating parts so much beyond our reach. A little meddling on the part of the surgeon might have obstructed the reparative processes which were safely proceeding to a happy result, and which he never could have so effectually forwarded, as by leaving the matter to be effected by nature's own handiwork.

Contraction of the left Auriculo-Ventricular Opening.

Dr. M'Dowel exhibited a recent specimen of this disease. The history of the case in which it occurred was as follows:—

Case.—A young woman (twenty or twenty-one years ago) was admitted under his care into the Whitworth Hospital one week before her death. She stated that six years previously she had an attack of rheumatic fever, in the course of which her heart was affected, and leeches were applied over the cardiac region. Soon after her recovery, she began to suffer from the symptoms of a disordered heart, such as uneasiness about the præcordia, palpitations, and difficulty of breathing, upon even slight exertions. Her general health, however, was good, and a year and a half ago she married; six months ago she had a child, which she nursed up to the time of her admission.

Soon after this child was born she had an attack of paralysis of the right arm and leg; the face also was distorted. The paralysis was but transient; for although she "dragged" the leg a little for some weeks, she ultimately recovered complete power over it as well as over the arm; but about this time the cardiac symptoms became greatly aggravated, and obliged her to come to hospital. For some days previously she vomited blood in large quantities.

Symptoms on Admission.—On the day of her admission she was almost in a dying state, but under the use of diffusible and other stimulants she rallied for a few days. The following symptoms were then observed and verified on repeated examinations:—

The heart's action was most tumultuous, violent, and irregular; it presented that peculiar "jogging" impulse which has been often stated to indicate an adherent pericardium. The second sound could be clearly distinguished, and *no bruit* could at any time be detected either at the base or apex of the heart.

Jugular pulsation was developed to a remarkable degree, and appeared to have existed for a long time, as the veins at the root of the neck on each side were dilated into large bulbous sinuses, in which the observer could *read off*, as it were, every impulse communicated by the right cavities of the heart. The radial pulse was excessively feeble and irregular, contrasting remarkably with the strong impulse of the heart. The lips and cheeks were excessively livid; but there was neither dropsy nor dyspnœa; in fact, the only thing the patient ever complained of, up to the time of her death, was the excessive distention of the breasts with milk. Her mind was unaffected.

From these symptoms, coupled with the previous history of the case, Dr. M'Dowel said he had thought that the elements existed for attempting to establish a differential diagnosis; and he believed there would be found an adherent pericardium, mitral contraction, and excessive dilatation of the right cavities, with tricuspid regurgitation.

Twenty-four hours before death *jaundice* took place, and now delirium was observed for the first time. For nearly two days before death the pulse at the wrist was not perceptible.

Post-Mortem Examination.—The pericardium contained a good deal of bloody serum (the result probably of transudation); the heart was of large size, but the right ventricle considerably exceeded the left in size, and the apex of the heart was formed by the right ventricle only. The left ventricle was slightly hypertrophied; the left auriculo-ventricular opening was much contracted, having a narrow funnel-shaped passage into which only the top of the fore-finger could be passed. The left auricle was of great size; its muscular coat was greatly thickened; the left auricular appendix was singularly enlarged. Viewed from the side of the auricle, the contracted mitral opening presented the appearances so graphically described by Mr. Adams, being reduced to a "semilunar fissure," the concavity of which looked backwards; the openings of the pulmonary veins were of large size. The lungs were much congested and œdematous.

The right cavities of the heart, and the vessels connected with them, were preternaturally large. The pulmonary artery and aorta were, in this respect, remarkably contrasted: the latter was not larger than the little finger, the former was probably larger than usual.

The aorta seemed to have adapted itself to the diminished quantity of blood sent into it by the left ventricle, the proper supply of which was cut off by the diminished mitral opening.

As permission had been given to examine the thorax only, the other organs were not examined.

The connexion of the symptoms with the pathological changes above described was then dwelt on.

In conclusion, Dr. M'Dowel said, that this case was an example of mitral contraction *without regurgitation*, and therefore unaccompanied by *bruit*. The diagnosis rested consequently on general signs; these were, the remarkable disproportion between the heart's impulse and the radial pulse; the evidences of obstruction to the pulmonary circulation; and more remotely of hepatic congestion, of which hematemesis and jaundice were the direct indications.

Under such circumstances, the absence of dropsy and of pulmonary distress was not a little remarkable. The two organs chiefly affected, secondarily to the heart, were the brain and the liver; the brain suffered from the diminution of its proper supply of blood (hence the transient attack of paralysis); the liver suffered, in common with the parts behind the strictured opening, from the retardation of its circulation, and consequent congestion of its tissue.

This case, Dr. M'Dowel said, further tended to establish the value of "venous pulsation" as an indication of tricuspid patency, and the insufficiency of the "jogging impulse" of the heart, as an evidence of pericardial adhesion.

Ovarian Dropsy.

Dr. Corrigan presented a specimen of ovarian dropsy. It was from a patient who died of the disease at the age of thirty-four. The tumour was multilocular, and with this peculiarity, that it consisted of one very large sac, capable of containing twelve quarts, and giving to the abdomen much of the shape presented by pregnancy, with a congeries attached of small semisolid cysts of varying sizes occupying the cavity of the pelvis and iliac regions. It was remarkable for its rapid growth, having only made its first appearance last December, and attained so large a size in May as to render paracentesis absolutely necessary to prevent death from pressure and suffocation. The operation was performed six times without a single bad symptom following. The congeries of smaller tumours continued, however, still rapidly to grow, and on the 26th October, in tapping for the seventh time, the trocar entered one of the smaller tumours, which was followed by low peritoneal inflammation and death.

The details of the case, and nature of the operation performed, will be found in a clinical lecture by Dr. Corrigan in our next Number.

SELECTIONS FROM BRITISH AND FOREIGN JOURNALS, &c.

On the Action of Digitalis upon the Uterus. By W. Howship Dickenson, Esq.

The writer commenced his paper by stating that during the month of October, 1854, a patient in St. George's Hospital, labouring under most severe menorrhagia, was cured by the infusion of digitalis, exhibited for the relief of cardiac affection, from which she also suffered. In consequence of this he had been induced to try the remedy, by the permission of Dr. Lee, in a series of cases of uterine hæmorrhage which had occurred in the hospital. These cases, of which a table is given, were seventeen in number, and the general results of their treatment were as follows:—In every case of uterine hæmorrhage, unconnected with organic disease, requiring the employment of active remedies, admitted into the hospital after October, 1854, the administration of digitalis was had recourse to as the sole treatment, and the discharge was invariably arrested by it. The time which elapsed before the hæmorrhage subsided varied with the dose in which the digitalis was exhibited. When large doses were given, as an ounce to an ounce and a-half of the infusion, the discharge never appeared after the second day; when smaller doses, it never continued beyond the fourth day. In uterine hæmorrhage connected with organic disease, the remedy acted with less certainty; its exhibition was required for a longer time, and the effect was sometimes transient. The author then spoke of the mode in which the digitalis operated in controlling uterine hæmorrhage; and after concluding that its effect could not depend on the sedative influence of the drug in the heart and arteries, he showed, by various experiments and observations, that the arrest of the hæmorrhage was due to the action of the digitalis on the ganglia of the uterus, by which the organ was stimulated, and the muscular substance powerfully contracted.

Means of preventing the Decomposition of Potassio-Tartrate of Antimony in Solution.

Harms states that the decomposition of this salt in solution is prevented by an admixture of alcohol. He recommends that the salt should be dissolved in fifty parts of water, and that ten parts of alcohol should be mixed with the solution.

Transmission of Newspapers.—By a Treasury warrant, dated December 7th, inst., the rate chargeable on newspapers transmitted from the United Kingdom to any British colony or foreign ports, *via* Panama, shall be 1d. each. On colonial newspapers between one British colony and another, *via* Panama, 1d. each. On foreign newspapers, 1d. each.

DUBLIN: PUBLISHED BY W. B. KELLY,
8, Grafton-street.
LONDON: S. HIGHLEY, 32, Fleet-street.
EDINBURGH: MACLACHLAN & STEWART.
December 15, 1855.

DUBLIN: PRINTED BY J. M. O'TOOLE, 13, HAWKINS'-STREET.

PUBLISHED ON THE 1st AND 15th OF EACH MONTH.
SENT FREE BY POST.
Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 23.—Vol. II. JANUARY 1, 1856. Price 5d.

Clinical Lecture on Ovarian Tumour—Case of—Rapid Growth. Diagnosis from Pregnancy and Peritonæal Dropsy—Operation for Relief of—Peculiarity of Operation recommended.

BY DR. CORRIGAN,

PHYSICIAN TO THE WHITWORTH AND HARDWICKE HOSPITALS.

Case reported by Mr. Comyn, *Clinical Clerk.*

The preparation before us to-day is an ovarian tumour. The case has been under our observation for some months.

The points of interest which it presents are, its nature—its rapid growth—its illustration of the diagnosis of ovarian tumour, and the operation. With regard to the first, its nature, it is multilocular, and of two different formations; it consists, it will be observed, of two very distinct portions: one, a very large simple cyst, occupying the upper portion,—the single cyst capable of containing several quarts,—on one occasion twelve quarts of fluid were extracted; the other, consisting of a congeries of cysts of varying sizes, from that of a grape to that of an orange, filled with a semigelatinous curdy fluid: these smaller cysts agglutinated and forming one large, irregular mass, which extended from ilium to ilium, forming the nodulated tumours which were felt through the abdominal parietes during life.

Secondly, its rapid growth.—The patient C. W. was a married woman, ætat. 34; she had had four children, and the first symptom she felt was swelling, last Christmas, about the pelvis, which she supposed was from pregnancy. The swelling, however, rapidly increased, accompanied with very diminished action of the kidneys; and continuing still to increase with rapidity, and to incommode her very much, she was admitted into the Whitworth Hospital in May. She was then very much emaciated; blue veins, of considerable magnitude, traversed the surface of the abdomen; the tumefaction of abdomen was very considerable; the skin generally was remarkably fair, the sclerotic very white, the pupils very large, and altogether the appearance that of a person of very strumous diathesis. The tumour continued still to enlarge with such rapidity, that within a fortnight after admission it was obvious that life could not exist much longer without relieving her from the pressure, as the tumour pressed the diaphragm up so far as to impede respiration, and she was helpless from its weight and bulk. The tumour was tapped, and about twelve quarts of semigelatinous dark-coloured fluid extracted, and the operation was again repeated in a fortnight: no bad symptom followed; she left the hospital able to walk about, and greatly improved in health and strength. In six weeks she returned, the tumour having again increased to nearly its former size; the tumour was again tapped, and the operation was twice repeated within three weeks, without any unfavourable symptom following. She left the hospital again in September, but returned on the 26th October, with the tumour enlarging; but on this occasion it was evident, on examination, that her state had become more unfavourable, for the smaller and more solid congeries of tumours, which before had been merely perceptible, now occupied the hypogastric and iliac regions from side to side. As the pressure upwards had become very urgent, tapping was again employed, and relief as before obtained, but the solid mass remaining was greater than on any former occasion. In the last week of November, the pressure had again become urgent, and tapping for the sixth or seventh time was performed; on withdrawing the trocar, however, on this occasion, instead of the dark, homogeneous, semi-gelatinous fluid which had flowed on former occasions, a curdy semi-transparent fluid, mixed with flakes, with difficulty found its way through the canula, and a probe, introduced through the canula, passed through septa breaking up before it. The wound was closed, and the trocar was introduced higher up, out of reach of all the smaller and harder cysts; a large quantity of the usual dark-coloured fluid was discharged, but the day after, symptoms of low inflammation of the peritonæum and mucous membrane showed themselves; vomiting of green fluid, fiery redness of tongue, pain on pressure, erysipelatous redness of integuments, and very quick pulse. She died in two days afterwards.

The third point is the illustration of diagnosis of ovarian disease afforded by this case. It might have been confounded with pregnancy, or with peritonæal dropsy. It would be out of place to go into all the lengthened details of diagnosis. I shall confine myself to the most certain—the physical diagnostic signs. An enlarged uterus, and the ovarian cyst, as in this case, would equally produce an oval, smooth prominence in the abdomen, and would equally give dulness on percussion as far as the prominence extended; but the enlarged uterus would not give the distinct fluctuation which was perceptible in this case on palpation. The disease might be confounded with ordinary peritonæal dropsy, from the distinct fluctuation which was so perceptible in consequence of the great size of the large superior cyst, the thinness of its walls, as well as the extreme thinness of the abdominal parietes; but change of position shewed that the fluid was contained in a cyst, situated in front of the intestines, for the anterior portion of the abdomen was dull on percussion, no matter how position was altered, while in peritonæal dropsy, alterations of position, it is well known, in nearly all cases, cause corresponding alterations of dulness and clearness of sound on percussion, according as the intestines, distended with air and fluid, change their relations of level. In this case also percussion of the lumbar region very far back gave useful information, for, as the patient lay on her back, and percussion was made passing down from the umbilicus on each side into each lumbar region, the sound became clearer over each side between the short rib and crest of the ilium, showing that the intestines were forced back into this situation, and were not surrounded by a free fluid, which would have permitted them to float through it.

The fourth point includes the circumstances of the operation performed so often for her relief. Ovarian tumours differ so much in size and structure, that it is idle to speak of them as a class of diseases to be treated on any general principle; each must be considered and treated *per se*. In the present case there was no time, even if it held out any hope of success, of attempting absorption by medicine. The operation of excision we may now consider as abandoned, unless in cases where it is not necessary, and then it is not justifiable; so that we were reduced to paracentesis, and the only question remaining was, whether it would be more advisable to close the opening after discharging some fluid, or to keep it open, allowing the cyst to take on a purulent action, and contract in itself as hydroceles of the neck do. There was this consideration in favour of the latter, that there was adhesion of the large cyst to the peritonæum, for the most careful and repeated examination could detect no sound of frottement on moving the abdominal parietes to-and-fro; but then, on the other hand, the highly marked strumous diathesis of the patient, and the presence of the great number of smaller and hard tumours in the pelvis rendered it, I may say, quite certain, that a process of suppuration, if established, would certainly prove fatal by exhaustion and irritative fever. There remained, then, only the operation of paracentesis, and to some particulars connected with it I would beg to draw attention. There are two modes recommended for this operation: one to draw off the fluid by small portions at a time, to save the patient from the exhaustion consequent on the removal of such an amount of pressure from the circulation; the other, to draw off the whole quantity at once, taking care to have the abdomen well swathed, so as to substitute an external pressure for the pressure of the fluid removed. The first mode has no definite rule for the quantity to be removed, and involves, if only very small portions be removed, very frequent repetition of the operation. The second, that, is the operation of discharging the whole quantity of fluid at once, and maintaining an outward pressure by bandage, has I think, this very serious danger attendant on it, that by evacuating the contents at once, and imposing an outward, and, as it must be, a considerable pressure on the sides of an unhealthy structure, the walls of the cyst are brought in friction against one another; duplicatures or folds are produced in a structure of low vitality and power, the circulating and vital nutritive functions going on in it are readily impeded, and a low inflammatory or congestive action is readily set up, which will quickly propagate itself, and as we know it is a law in inflammation of serous membranes, that inflammation will spread from contiguous surfaces, the unhealthy inflammatory action that may be originally confined to the empty cyst will propagate itself on the opposing surface of the peritonæum, and thus the amount of disease and of danger will be much increased. I would beg to submit the plan followed in the several tappings practised in this case, and what would appear to me to be deserving of consideration, as free from the objections attendant on the two modes noticed. It is to allow the fluid to flow without using bandage or pressure, neither closing the orifice too soon, as might be done in compliance with the first rule, nor forcing out all the fluid with the consequent danger adverted to from adopting the second plan; simply to allow as much of the fluid to flow gradually out as the natural elasticity of the distended cyst, and the corresponding return of muscular tone in the parietes of the abdomen and of the diaphragm will expel; and when the flow has quite ceased of itself, to close up the orifice, the patient of course retaining the recumbent position. The observance of this simple rule, I believe, gives us a measure of the proper portion to withdraw without the danger of producing exhaustion, and avoids, on the other hand, the danger that I have already adverted to, as attendant on the sudden withdrawal of the whole contents of the cyst. I believe I have also seen great safety from this mode of operation, in some of those diffuse abscesses in the neck accompanying scarlatina, in which the diseased cellular tissue has lost its elasticity, and cannot follow with corresponding contraction the sudden evacuation of the whole contents, but in which, if the matter be allowed merely to flow out by the *vis a tergo* without any handling or external pressure, the surrounding parts will follow up with slow but steady and corresponding contraction, the gradual flowing out of the matter; and the entrance of air, and duplicatures and friction of unhealthy structures upon themselves will be avoided. The last, or seventh operation, in W.'s case, was followed by fatal result, but this does not I think affect the question under consideration. The pelvic tumours were rapidly increasing in size, and must soon have terminated life, and one of these, a structure of low vitality was wounded by the trocar, and it was upon this the fatal inflammation arose. The point worthy of consideration is, that under unfavourable circumstances of constitution, and accompanying disease of rapid growth, a large ovarian tumour, containing from ten to twelve quarts of fluid, was tapped six times without a single unfavourable symptom, by conducting the operation on the principle above explained.

CASE OF PURPURA WITH SCURVY.

BY AQUILLA SMITH, M.D., M.R.I.A.,

PHYSICIAN TO SIR PATRICK DUN'S HOSPITAL.

Captain J——, æt. 45, was admitted on the 21st of September, into one of the pay-wards in Sir Patrick Dun's Hospital.

He has been engaged for near thirty years in vessels trading between Dublin and the West Indies, and was at sea for eighteen months previous to his admission. When on shore at Trinidad, last July, he got some pills from a doctor which did not relieve him; on the passage home he was thrown, by a lurch of the vessel, against the table in his cabin, and the fifth, sixth, and seventh ribs of his right side were fractured, which continue to give him pain when he breathes or makes any exertion. There is very little swelling over the site of the fractures, and slight pressure causes pain; but there is not any affection of the pleura.

There are many florid spots of purpura on his legs, and there is a large vibex on the outside and middle of the left thigh; another, but smaller vibex, is on the outside of the right thigh, a little above the knee. Those vibices are oblong, slightly elevated in the centre, of a blueish colour, and painful on pressure, or when he attempts to walk. The patient, who is very intelligent, was impressed with the notion that abscesses were about to form, and stated that his object in coming to the hospital was, to have the supposed abscesses treated, for he did not attach any importance to the spots of purpura, though he believed that he had been affected with scurvy for more than two months. The middle incisors of the upper jaw had fallen out in consequence of the diseased state of his gums, and at the base of the lateral incisors the gum is much swollen, of a dark purple colour, and bleeds when he attempts to brush his teeth; the gum of the lower jaw is detached from the teeth, and forms two large purple flaps somewhat like a cock's comb. His joints feel very stiff—there is great debility, pallor of the face, and loss of appetite, particularly for meat; pulse soft, feeble, but not accelerated; skin moist, and bowels regular, from the occasional use of a mild aperient; tongue clean.

There was lime-juice on board, but the captain could not use it in consequence of the nausea it caused; and five of the crew had scurvy, though the lime-juice was freely given to the men.

A belladonna plaster was placed over the fractured ribs, and a broad calico bandage was passed round the chest for three or four turns, which enabled him to breathe and move without pain.

No medicine was prescribed; he was ordered for breakfast, bread and butter, with tea; for luncheon, strong beef tea and bread; and for dinner, well boiled potatoes mashed up with plenty of butter; and to have a bottle of English cider for drink during the day.

Sep. 22.—The day after his admission, strong nitric acid was carefully applied to the diseased gums, by means of a piece of soft wood moistened with the acid, and his nostrils were closed by an assistant while the acid was applying.

Two ounces of sherry wine ordered in addition to his diet.

September 24.—The spots of purpura are faded, and the gums are paler and less swollen. The nitric acid was again applied, and did not cause any pain worth notice.

September 26.—The vibices have lost the blueish colour, and are now greenish in the centre, and yellowish at the margin; they are less swollen, and not painful on pressure. The gums are so much improved, a solution of twenty grains of nitrate of silver in an ounce of water was substituted for the acid.

October 2.—The patient feels better in every respect, the same diet has been continued for the eleven days since his admission, and the only medicine taken in the interval was a rheubarb draught.

The gums are much better, and he can now use his tooth-brush without causing them to bleed; two small florid elevated spots were touched with sulphate of copper. The purpura vanished some days since, and the vibices have nearly disappeared; the patient is now able to walk about the ward without inconvenience; he sleeps well, and his appetite is so much improved, he desired to have a mutton-chop for dinner, which was ordered along with four ounces of claret, a few bottles of which were supplied by his employer.

October 11.—The patient considers himself to be in perfect health; his gums are restored to their natural size and appearance as to colour; he has no pain in the site of the fractured ribs; and he left the hospital, having been twenty days under treatment.

December 11.—I saw my patient this day; his gums were perfectly sound, and he had gained flesh and strength.

This is not the first case of purpura which I have treated successfully on a diet consisting chiefly of potatoes and butter, together with the free use of cider, and in one very aggravated case of purpura hæmorrhagica, in which the bleeding from the gums was so profuse as to endanger the life of the patient, I effectually checked the bleeding by the application of strong nitric acid, after having failed to suppress it with Ruspini's tincture and other styptics.

I may take this opportunity of alluding to the treatment of scurvy by lemon-juice, a remedy which has been in use in the east from a remote period.

In 1646, I. Baptista Ferrarius, a learned Jesuit, published at Rome a folio volume; the title of the book is "Hesperides sive de Malorum Aureorum Cultura et usu;" chapter 35 is headed "utilitas apud exteros;" and at page 364 the following words are in the margin, "E limone remedium contra scorbutum."

A very explicit description of scurvy is given in the text, and the efficacy of the remedy is clearly stated in the following extract: "Sed Franciscus Martinus Vitræus, ex iis unus gallicæ sociis expeditionis qui trajecere in Indiam primi, quique prædictum morbum oculata cognitione perspexere, perbrevi opusculo, scorbuti causas, damna, et medicamenta complexus, apertè ait, nullum esse contra scorbutum præmuniens remedium valentius, quám si limonis, seu citrei, sive aurantii succus præsumatur: vel poma eadem comedantur: vel limonis syrupus adhibeatur. Nullum præterea scorbuto removendo præstantius antidotum limonis et aurantii succo, aut pomorum eorundem syrupo invenire."

At page 478 the use of oranges in rheumatism is mentioned as follows, "Dulcia [aurantia] enim utpote calidioris habitudinis, dantur melancholicis, rheumatismo laborantibus, quibus viscerum obstructi sunt meatus, et senibus."

PATHOLOGICAL SOCIETY OF DUBLIN.

December 8, 1855.

THE PRESIDENT, DR. STOKES, IN THE CHAIR.

Degenerative Disease of Kidney; Peritonitis &c., &c.

DR. BANKS stated, that the subject of this disease, a man, aged forty, was admitted into the Whitworth Hospital, labouring under general dropsy; his health had been good up to a recent period, but his habits had always been most intemperate. Two months before his admission he had been discharged from the Richmond Hospital, where he was under the care of Mr. Hamilton, for a considerable time, with an enormous anthrax of the back.

A fortnight before he came into hospital he perceived that his face was swollen, and soon afterwards his legs became enlarged. He, also, had a severe attack of diarrhœa, which still continued when he came under observation. He bore the aspect of a man in rather an advanced stage of Bright's disease, the body was universally anasarcous, and the face was puffy and anæmic; cough and slight acceleration of breathing were present; the urine was rather below the normal standard in quantity, sp. gr. 1,027, and did not contain albumen.

There was nothing worthy of note in the progress of this man's complaint for the first week, but at the end of this period, he was seized with violent rigors, soon followed by pain in the abdomen, and exquisite tenderness on pressure. The symptoms of peritonitis were of excessive severity, and being unrelieved by treatment, he succumbed on the third day to the disease; a dusky patch of diffused redness was observed on the side of the abdomen, and on one thigh shortly before death.

Autopsy.—On opening the abdomen signs of extensive peritonitis were observed, arborescent vascularity of the serous membrane, and cream-like lymph existed in some situations; serum and purulent matter in considerable quantity flowed out.

The liver was enlarged and slightly rough on the surface, like the incipient stage of cirrhosis. The kidneys were large, one weighing 10, and the other 12 oz. The capsule easily separable, and the surface, slightly irregular, was generally pale, but in some situations stellated, vascular patches existed; a section exhibited the cortical substance very much thickened, and the medullary cones somewhat enlarged. The cortical substance was of a yellowish hue, closely resembling the appearance of a Swedish turnip. The consistence of the kidneys was firmer than natural. A microscopic examination of the cortical substance revealed the presence of a small quantity of fat; the tubuli were enlarged and filled with a pale amorphous deposit. On examination of the thoracic organs, the right lung was found to contain tubercles scattered through its substance, and at the apex a very small cavity. The left lung was enveloped with a dense layer of lymph, and the parenchyma in parts cirrhosed. There was no lesion of the heart.

Dr. Banks observed, that the case he had brought before the society presented an unusual combination of disease. It should be remembered, that the subject of it was a person of exceedingly intemperate habits; he was, moreover, from the nature of his occupation, exposed to cold and much hardship; he had also, at times, suffered from privation. The progress of the disease, or rather diseases, was exceedingly rapid, as, according to his statement, he was in apparent good health a fortnight before his admission into hospital; that his constitution was in a depraved state, and thus ready for the reception of morbid influence, may be assumed from the fact of his having so lately an anthrax of great extent on his back.

It is worthy of notice, that on being admitted into hospital the urine was of high density, and did not contain albumen. The absence of albumen, however, was only temporary, for shortly before death the urine, though still unusually high in density, considering the disease, was albuminous, and contained, also, a notable amount of bile. It is difficult in this case to decide which of the diseased conditions under which he laboured was the first link in the chain of morbid action.

The occasional occurrence of acute serous inflammations, in the progress of Bright's disease, is well known, but in this instance the peritoneal inflammation may be looked on as a diffuse type, from the existence of the patches of dusky erysipelatous inflammation on the abdomen and thigh. The kidney presented one of the forms of renal degeneration, met with in Bright's disease, the pathology of which, notwithstanding the researches of the distinguished physician whose name it bears, and the contributions of Christison, Rayer, Frerichs, Gairdner, and others, still requires elucidation. It is up to the present undecided, whether the large kidneys, such as that exhibited to the society, ever becomes, in the progress of degeneration, the small atrophied, contracted kidney which we so often meet in this disease. The probability is, that it does not; at least we find the large kidney, in cases of Bright's disease, the progress of which has been exceedingly chronic, and thus affording ample time for the organ to undergo the change. By some pathologists, the large degenerated kidney is supposed to be connected with phthisis, and the cognate affections, and the presence of tuberculosis of the lung in this case would, so far as it goes, lend support to this opinion.

Polypus Uteri.

Dr. M'Clintock exhibited a polypus which he had removed from the uterus of a patient in the chronic wards of the Lying-in Hospital. Its extirpation was effected by the ligature, which took five days to cut through the pedicle of the tumour, as this was of considerable thickness. After its connexion with the uterus had been severed, there was some difficulty in withdrawing it from the vagina, owing to its bulk and globular shape. It was about as large as a goose's egg, and weighed nine ounces. In structure it was fibrous, but did not present the same degree of density that fibrous tumours ordinarily possess. A portion of the growth, from near its centre, was examined under the microscope by Mr. Richardson, who found it to consist of a fibrous and fibroid tissue, the latter presenting almost identically the same characters as the proper tissue of the healthy uterus. For the sake of comparison Mr. Richardson examined at the same time, a specimen of the unimpregnated uterus, and found the resemblance between this and the fibroid structure to be most striking: thus, so far, confirming the view of the muscular character of these growths.

Coagulum in the Pulmonary Artery, and Emphysema of the Lungs in Typhus Fever.

Doctor Gordon detailed the particulars of a case of typhus fever, in which a firm coagulum was found in the pulmonary artery, producing emphysema of the lungs.

Dr. Gordon divided typhus fever into the maculated and non-maculated forms according to the condition of the blood, whether it contained an excessive or diminished quantity of fibrine.

His communication will be found at greater length in our last Number; see page 343.

Scrofulous Tubercle in the Brain.

DOCTOR MAYNE presented a specimen of scrofulous tubercle in the brain. The patient had suffered for a considerable time from intense pain in the head, which resisted all treatment. There were no concomitant signs of tubercular development in any other region which could assist in forming a diagnosis, although after death tubercles were found in the lungs.

The case will be detailed at length in our next Number.

Fibro-Cartilage removed from the Knee Joint.

DR. SWETTENHAM, Staff Surgeon, presented a small fibro-cartilaginous tumour which he had removed from the knee joint of a soldier who had been sent from his depot at Mullingar in July last, 1855, with a view to being discharged the service on account of a foreign body in the right knee joint. On his admission his general health was very good, and he stated that some time previous he sprained the right knee whilst wrestling with a comrade, and subsequently discovered the foreign body in the joint, which latterly gave him some slight pain in marching. The tumour was very perceptible, it floated from side to side under the patella, and could be placed in position at any part of the joint by the will of the patient. The medical officer who first saw it endeavoured to fix the body; which was likewise attempted in the general hospital by means of a leather knee-cap which buckled round the joint; in this, an orifice of about the size of a crown piece was made, corresponding to which space the foreign body was brought at the external and anterior part of the joint. A compress and bandage was applied, and the body was fixed at this point, and left in this position for several days, but on examination after a certain period, the body was always found to have escaped from its place of confinement. The apparatus was removed, and he determined to remove the cartilage by excision. On the 28th of September he removed it from the joint, by making an incision on the inner side of the knee, having fixed the body at the reflection of the synovial membrane from the internal head of the tibia; the convexity of the incision was directed downwards, and it was of a valvular nature; the foreign body was fixed with the left hand, a very small opening was made into the synovial membrane, and the foreign body was forced through it in its long axis, air and blood being carefully excluded. The wound was then brought into apposition and one suture applied, over this a few adhesive straps, and the whole surface thickly covered over with gutta percha collodion. After a few hours, ice in bladders was kept to the joint, and the patient directed to observe strict rest in bed; very slight pain followed, and no inflammation set in. The ligature was removed on the first of October, the wound healed favourably, and not the slightest appearance of constitutional disturbance succeeded the operation. A small quantity of calomel and opium was administered from the above date, the joint presenting a slight puffy appearance, which subsided under this treatment and the application of a cold wet bandage until the wound completely healed; it was not necessary to affect him by the mercury; and about the 20th, the wound having perfectly healed, he was permitted to use the limb, and walked well, without any annoyance; being a smart, active man and his health good, he was allowed liberal diet, and discharged, cured perfectly, on the 30th October to join his corps for duty.′ The fibro-cartilage an inch long, and half an inch broad.

December 15, 1855.

THE PRESIDENT, DR. STOKES, IN THE CHAIR.

Acute Meningitis with Softening of Substance of the Brain.

DR. LEES produced to the Society the brain of a young woman, aged eighteen, who had come up to Dublin about two months previously in the capacity of a servant, at which time she was apparently in the enjoyment of robust health, but had been subject to much anxiety of mind from family dissensions. Soon after her arrival in town she began to complain of severe headaches, occurring at intervals. On Sunday, November 25, a very violent attack came on, accompanied with frequent vomiting. She was then seen by a practitioner, who prescribed some medicines; but the symptoms continuing, Dr. Lees was sent for, when he found her complaining of severe frontal headache, with intolerance of light and frequent vomiting; her skin was hot and dry; tongue furred; bowels costive. He at once recognized the case as one of acute cerebral disease, and recommended her removal to Sir P. Dun's Hospital, when she came under the care of Dr. Aquilla Smith. The vomiting now ceased, the pain in the head and intolerance of light diminished, and the pulse fell to 80 on the day after admission; next day (1st) the general symptoms of fever continued; but the pulse fell to 72; and the pupils were slightly dilated; there was no suffusion of the conjunctiva, nor increased action of the temporals or carotids; and her intelligence was perfect. 3rd.—She was found this morning in a state of insensibility; could not be roused; pupils dilated; respiration tranquil; no stertor; pulse 72. 4th.—She recovered her senses after a large blister was applied over her head, and was now perfectly conscious of everything; but the pulse was 104. Both pupils were dilated, particularly the left; and there was ptosis of that lid. She kept the clothes pulled up about her neck and head, as if she was cold; she lay in a listless state, did not like to be disturbed, and complained if the slightest pressure was made on any part of her body, even from the stethoscope being applied. There was great tenderness along the spine, particularly in the cervical region; she also screamed occasionally, but answered questions rationally when spoken to; she had passed urine and fæces unconsciously since the 3rd. 5th.—same state; p. 112. 6th.—120. 7th.—128. 8th.—132. 9th.—140. She continued in the same state, singing occasionally, and screaming at night, but answering questions rationally, and complaining of pain in the forehead, till the 14th, when her respiration suddenly became accelerated, and she died quietly on the 15th, without any convulsion. The *post mortem* examination was made some hours after her death, by Mr. Daniell, when the scalp was observed to be remarkably dry, almost bloodless. On removing the calvarium and dura mater, there appeared much venous congestion, with bright-red arborescent vascularity on the surface of the brain, but no appearance of lymph. On proceeding to remove the brain about two ounces of a turbid serous fluid escaped from the base and theca vertebralis; the base of the brain, especially about the optic commissure and fissure of Sylvius, was thickly coated with a jelly-like lymph, which united the anterior and middle lobes of the cerebrum. The lateral ventricles were dilated, and contained about half-an-ounce of serous fluid; there was no appreciable change of structure in the brain itself, except at the septum lucidum and the commissura mollis, which gave way on the least touch, and appeared diffluent and white like cream. Dr. Lees observed, that though there existed much difference of opinion among authors as to the distinctive symptoms of inflammation in the arachnoid and pia mater, and in the substance of the brain itself, yet he thought that the most important point to decide was, whether inflammation was present or not. That the symptoms in this case depended on actual disease of the brain, was inferred from the history of the case, from the symptoms she presented when first seen, and from the pulse reducing in frequency, though the other symptoms continued the same; the temporary improvement in her symptoms was also very remarkable, first, under the influence of mercury, and, secondly, from the iodide of potassium; the retention of her faculties up to within a few hours of her death, though such extensive disease was present, and also the peculiar sensitiveness she suffered from pressure being made on any part of the body was worth recording, particularly in connexion with the softened condition of the central parts of the brain, for though this symptom has been noticed in cases of cerebro-spinal meningitis, yet there were no other symptoms indicative of the disease. He was not permitted to examine the chest, but he might state that a careful stethoscopic examination had been made by Dr. Law, Dr. A. Smith, and himself, and there was no evidence of any disease.

Encephaloid Disease of Stomach.

Dr. Hughes exhibited a liver affected with medullary or encephaloid cancer. The specimen was obtained from a female, aged thirty-six, who died three days after her admission into hospital.

The immediate cause of death was the bursting of one of the cancerous growths into the peritoneum, causing peritonitis. The liver was greatly enlarged, filling a great part of the abdominal cavity, and ascending high into the chest. On the convex surface and free margin were several large tubera, some the size of a small orange. They were prominent, soft, and elastic; and when cut into exuded a creamy fluid. They were also extremely vascular on the surface. The disease was confined to the liver and lesser curvature of the stomach.

During life there was jaundice and slight ascites. Dr. Hughes showed another specimen of the same disease, which occurred in a man aged fifty, who had been under observation in the hospital more than four months. In this case also the liver was greatly enlarged, and weighed eleven and a-half pounds. It presented a striking specimen of the disease in every stage of development and growth; and in several of the tubera the central depression was well marked. The cancerous growths attained a much larger size in this instance than in the former, but they were firmer to the touch, and protruded far beyond the surface. The patient had slight anasarca of the lower extremities; but no jaundice. He died gradually, worn out and exhausted; and the disease had spread to the pylorus, lesser curvature of the stomach, and was disseminated through the structure of both lungs.

Enlarged and Hardened Liver with Jaundice.

Dr. Corrigan presented a contribution to the pathology of the liver. The patient, a girl ætat. sixteen, received an injury about nine months ago on right side of abdomen. She soon after began to suffer from enlargement and pain of side and epigastrium, and about three months since she became jaundiced. Dropsy followed slightly over whole body, but the effusion into abdomen became very great. On the 13th Dec. she was suddenly seized with vomiting and purging of blood, under which she rapidly sank, preserving her senses, however, almost to the last moment. During life the liver could be felt considerably enlarged, with a sharp edge, and of stony hardness. The evacuations, at first white on admission into hospital on the 26th November, soon after were moderately tinged with bile. The jaundice had decreased a little, but never altogether disappeared, and latterly had presented a slightly greenish tint. The urine was always deeply loaded with bile. On *post mortem* examination the liver was found of stony hardness, cutting like grit under the knife. It was not brittle, but firm and tough as cartilage, and of a dark olive green colour. The gall bladder was totally empty of bile, containing only a little mucus, even untinged. Its duct was clear, as well as the ductus communis. The cystic duct was clear until just as it emerged from the liver, where its calibre was so greatly diminished as not to permit the passage of a fine probe. This diminution was produced by a deposit of lymph, bedded partly in substance of liver, but extending into capsule of Glisson. This deposit pressed upon the duct, and was itself about the size of a hazel nut, appearing to act upon the duct in producing stricture of it in a manner similar to the effect of lymphy deposit around the urethra in causing stricture of that canal. The substance of the liver, when examined by Dr. Frazer under the microscope, showed deposition of bile in texture of liver.

Dr. Corrigan observed that this preparation was in illustration of those cases of hardened and enlarged liver without organic disease, most often observed in young persons, accompanied with remitting jaundice, that is, occasional or even frequent discharges of bilious stools and lessened jaundice, but not at any time with total disappearance of it, the duration of such cases often extending over very long periods of time. [For further details of case, &c., see clinical lecture in the next Number of the HOSPITAL GAZETTE.]

Stricture of Rectum.

DR. FLEMING presented two specimens illustrative of the varieties of "Organic Strictures of the Rectum," the situations which they may occupy, and the results to be anticipated from their presence.

1. *Organic Stricture of the Rectum. Non-Malignant.*—This specimen was removed from a man of the name of Campbell, who had died of fever within the last few days; he had been under the care of Dr. Fleming, in the Richmond Hospital; and the history of his case having been given in detail under the head of "Diseases of the Rectum," in the last Number of the DUBLIN HOSPITAL GAZETTE, it will be only requisite to remark on the present occasion, that the man died at the age of 27, that he dated the first symptom of disease of the bowels so far back as ten years, and that during this period of protracted suffering he had continued at the laborious work of a horse-shoer, with the exception of some weeks, about three years back, when he was a patient in St. Vincent's Hospital, with symptoms of dysentery. He had only applied to Dr. Fleming within the last two months, and then ostensibly for "fistula in ano." The examination of the morbid specimen, tended to confirm the opinion of the non-malignant character of the disease, as given in the published report of the case. The large quantity of healthy fat surrounding the anus and rectum, in their ordinary situation, bespoke an absence of emaciation to any appreciable amount, when the duration of the disease was considered. The complete isolation of the morbid lesion present was also an important circumstance. The mucous and submucous tissues were alone involved in it. The muscular coat exhibited merely some hypertrophy of its fibres, and the whole gut was so separable from the surrounding structure, as to be removed without the slightest difficulty. An excellent drawing by Mr. Connolly accompanied the specimen, and showed extensive disease around the anus. The integuments were thickened, œdematous, and inflamed; pendulous projections existed near the external sphincter, such as were described by the late Professor Colles, and considered by him somewhat pathognomonic of stricture within the gut. Fistulous openings were here also visible, communicating with the rectum above the sphincter, and a longitudinal section, through the anterior wall of the bowel, satisfactorily explained the following observations communicated during life:—"The finger detected within the gut extensive ulceration, and at about from an inch and half to two inches, it is obstructed by a thick shelving partition, which completely surrounds the tip, and merely admits it when some force is applied: any portion of the bowel which can be reached feels dense, contracted, and roughened, and closely presses on the finger as it advances." The peculiar colour indicative of chronic disease of the mucous membrane was well marked, and the irregularly thickened submucous tissues equally so. The stricture commenced about two inches from the anus, and almost the whole of the rectum was engaged in it, the diminution of its calibre being considerable. In its uppermost portions a fistulous canal was traceable anteriorly, where a mere film of delicate membrane protected the peritoneum against perforation. Dr. Fleming considered this affection of the rectum as "non-malignant," and the preparation a good specimen of the "scirrho-contracted rectum," first described by Dr. Sherwin in the "Memoirs of the Medical Society of London," mentioned by Professor Colles in his "Lectures on Surgery," and described under this same head, and subsequently specially noted by him in his invaluable paper on "Diseases of the Anus and Rectum,"

in the Dublin Hospital Reports. Dr. Fleming stated that he had met with this disease in very early life, and that he was disposed to consider it as identified with that state of the system termed "tuberculosis;" and that hence the substitution of "strumous or scrofulous stricture of the rectum" would, perhaps, prevent mistakes in its pathology.

2. *Organic Stricture of the Rectum. Malignant.*—For this specimen Dr. Fleming was indebted to his friend Dr. Henry Kennedy, who had already detailed the particulars of the case at a meeting of the College of Physicians. The individual from whom the specimen was removed was a man, aged 54. He had been a servant in comfortable circumstances, and in the enjoyment of good health, until within about three months of his death. His attack of illness commenced rather suddenly, with obstinate constipation, which had yielded to an extent to admit of his leaving hospital and resuming his duties. The symptoms of constipation returned, and all treatment to relieve them proved ineffectual. The man died, not of peritonitis, but exhausted by protracted suffering from obstruction of the bowels. On examination after death the whole intestinal tract was found enormously distended as far as the sigmoid flexure of the colon; here, at the commencement of the rectum or near it, there was a constriction of the bowel as indented and as circumscribed as if a piece of strong packing thread was tied around it. The remainder of the rectum, including the anus, was free from disease; it was empty, and contracted, and with the distended bowel above, bore no slight resemblance to the œsophagus attached to the stomach, and the contraction was so complete that it was perfectly impervious to fluid poured into either end. This specimen was so confirmatory, even in its minute details, of the statements made by Mr. Paget in his valuable Lectures on Surgical Pathology, when treating on "hard intestinal cancer," that with the lithograph he gives, they might be transferred for description. It exemplified the infiltration of hard cancer-structure into the submucous tissues of the intestines, causing contraction of the muscular and peritoneal coats around it, and a "concentric in-drawing of the growth itself," so that a complete annular stricture was the result. An additional interest was attached to the specimen, from the association of a growth into the cavity of the intestines (in the site of the stricture) of medullary cancer. This was rendered very manifest by a section through the morbid mass. The dilatations and the hypertrophy of the intestine above the stricture were important facts for practical reflection, and taken in connexion with the history of the case, lead to the opinion, as also noted by Mr. Paget, that, in such cases, the phenomena of ileus are chiefly due to the final paralysis of the dilated part. Hence we are not to date the origin of the disease to the time of the first manifestation of symptoms. Dr. Fleming exhibited some excellent illustrations of "hard cancer" in the duodenum at its commencement, in the ileo-cœcal valve, and also in the rectum, *external to the muscular coat*. He detailed its progress in contradistinction to the annular stricture above noted, arising from submucous deposit.

Correspondence.

To the Editor of the Dublin Hospital Gazette.

General Hospital in the Field,
Camp before Sebastopol, Dec. 8, 1855.

Sir,—In the Number of your excellent Journal for the 15th October, which, by some accident, only reached me within the last few days, there is an admirable detail by Dr. Joseph C. Wright, of the Royal Artillery, of the pathological appearances of a very remarkable and interesting case which occurred in the practice of Dr. Howard, of the 20th Regiment. As your readers will not have failed to observe, the phenomena developed towards the close of this case, and the results of *post-mortem* examination, were of a most unusual character; and if the case stood isolated, I am very doubtful whether its true pathological nature could be accurately determined. As I not only saw this case repeatedly during life, through the kindness of Dr. Howard, but made myself the pathological section with great care and interest, and as, moreover, the facilities for very extended pathological observations in the various hospitals of the allied camps, afforded me by those in authority, have brought under my notice several instances of this condition of disease, which I do not hesitate to pronounce one of the most *awful* I have ever witnessed, perhaps you will allow me to offer a few remarks, with the view of illustrating this very remarkable pathological state. One reason that makes me the more anxious to do so is, that in all probability, owing to the necessary delays of official publication, the records of my investigations, on this and other subjects connected with the pathology of the diseases of the army in the East, will not see the light for a considerable time.

With regard to the case in question, I may observe, that the patient was one of those fine light-built, but yet athletic, young fellows, about twenty-one or twenty-two years of age, whom, if at home, we would regard as admirably adapted to do credit to the skill of the surgeon, if by accident, or otherwise, he should be unlucky enough to come within the sphere of operations of the faculty. Here, however, the evils of Crimean warfare, and most especially the exhausting labours of the trenches, have so undermined the constitutions of those apparently of strongest frame, that a decidedly asthenic type of constitution prevails; the power of resistance to disease and to the results of injury, or to the shock of the greater surgical operations, is diminished in a remarkable degree: as I am in the habit of expressing it, the constitutional power of the Crimean soldier is, for the time being, below par. Yet, in using the simile of *undermining* of the constitution, the periphrasis is most accurate in its application, for, to all outward appearances, the men have, for the last six or nine months, presented the conditions of robust health. It was only when they came to be tested as to the real amount of their intrinsic *vis vitæ*, by the manner in which they supported the effects of great mechanical injuries, surgical operations of the higher kind, and graver forms of disease, that the pathological phenomena exhibited led us to estimate the deviations from the normal standard of health and constitutional power.

These deviations have been presented, I may add, to a very grave and serious extent; but your readers will doubtless be glad to learn, that in the large sphere of observation brought under my notice, I recently find reason for hoping, and indeed believing, that the standard of the constitutional powers of the soldier is being slowly, but gradually and steadily, raised, which is doubtless owing, among other things, to the improved and now very satisfactory condition of the camps, and the better working of the commissariat department.

I shall venture to append from my note book a few particulars of Dr. Howard's case, probably not known by Dr. Wright, as he was not present at the *post-mortem* examination.

The *sectio cadaveris* was made on the 7th August, about twenty-two hours after death. The temperature of this and the preceding day I have noted at about 80 to 85 deg., the latter being the maximum in the shade. The gaseous distention of the body and the frightfully distorted condition of the face made it utterly impossible to recognize a feature, and would, I conceive, have put identification, if necessary for any medico-legal purpose, quite out of the question. The tension and distention of the abdomen were extreme, while numerous blobs or large vesicles existed on its anterior wall. There was *immense* tumefaction with extensive blue discoloration and large epidermic vesication of the whole of the upper part of the thorax and neck. The globes and lids of the eyes were greatly swollen, and discharged much sanies. Large arborescent veins were observable on the thorax, arms, groin, and upper parts of the thighs: the surface generally was emphysematous, and crackled on pressure.

Gas escaped with great violence from the abdomen when first opened, and all the tissues were infiltrated with gas, while the intestines were distended to a great size.

The lungs presented large vesicles on the surface, and broke down immediately on the least pressure or traction, the fingers passing through their substance on the least attempt to grasp them; the parenchyma breaking down at once, but leaving a sort of framework of the vessels and tubes.

The pericardium was distended with gas, and the fatty tissue of the heart blown up; the heart itself was full-sized, round, and convex, but contained not a particle of blood; nor was there any in the great vessels.

The liver was covered with blobs or vesicles under the peritoneal coat; its colour was blueish black, while its tissue was soft, putrilaginous, and broke into a granular pulp on the least pressure. The spleen was soft and rotten; the kidneys on their surface, and to the depth of half-an-inch, were soft and pulpy, but the cones were a little more solid. The large intestines were of a dirty greenish black throughout, and were distended with a very fœtid gas.

The cava and iliac veins contained but little blood, but were full and round, being distended with gas: a couple of small transparent vessels crossed the lower part of the cava, distended in knot-like or beaded particles.

A very small quantity of dark, quite fluid, semi-serous blood was found in the iliac veins, while a somewhat purulent looking matter could be pressed with the edge of the knife from the swollen veins, both the tributaries of the iliacs and those on the surface of the thigh; there was some deposit of lymph in the lower three inches of the femoral vein; the femoral artery was pervious to the point of section.

In the stump, very slight union had taken place at the external edge of the flaps, but within, the texture was converted in a blackish putrilage.

The smell of all the tissues was very peculiar rather than intense. My researches on the curious subject of Histolysis have made me familiar with all the phases of decomposition; and I can say, that I have never, under the highest temperatures, seen changes, such as were affected in this and some similar cases within twenty-two hours after death, produced until after the lapse of very many days.

On the day in which I inspected Dr. Howard's case, I also made other *post-mortem* examinations, and found the *post-mortem* changes at their normal standard, so to speak, notwithstanding the high temperature of both day and night. We have, therefore, to seek some explanation for the rapidity and intensity of the changes produced in the case under consideration. I am not satisfied, however, that I am enabled to do more at present than indicate the pathological category in which it is to be ranked.

After very attentive consideration of a number of cases which have come under my observation, presenting many features in close parallel with those just detailed in Dr. Howard's case, I am led to believe that these very remarkable phenomena are the result of a process of sudden and general constitutional decomposition; the immediate origin of which decomposition is, I conceive, to be referred to a local, suddenly developed, but intense gangrene of the parts at the seat of injury, or operation, which, by a sort of *pathological catalysis*, determines, in the first instance, the decomposition of the blood, and through this medium that of all the tissues with which it comes in contact. It is remarkable that the various tissues and organic parts not only seem dead and spontaneously undergoing decomposition, as in ordinary cases; but appear to shew evidence of a destroying agency, which I would seek the explanation of in the sudden and, it may be, *explosive* decomposition of the circulating fluid, its chemical constituents assuming the gaseous form in a sudden and violent manner; the resulting gases in their expansion causing a mechanical separation and breaking up of the particles of the tissues.

I have now unhappily witnessed many examples of this affection. It has generally occurred in cases which have undergone the graver surgical operations; as, more especially, amputations in the upper and middle thirds of the thigh: but, I have likewise seen it after less serious operations. After the affairs of the 7th and 18th of June, the final assault on the Grand Redan on the 8th September, and the very lamentable catastrophe of the 15th of November, produced by the explosion in the French artillery park and English siege train of the Right Attack, several cases came under my notice, and from its effects, I, as well as others, had to deplore the loss of some of our very best surgical cases.

It will be my duty in another place, and in full detail, to enter into the consideration of the clinical and pathological history of this very fatal affection, and I have reason to think that the profession will be favoured with some valuable observations on it by my friend Dr. Mowat, Staff Surgeon, 1st class, who has, with such distinction, presided over the General Hospital in camp, during the eventful period of the campaign which has just drawn to a close. I shall, therefore, not trespass much further on your columns than to state, that while the clinical features of these cases presented very great variety, the chief pathological characters bore in general a very close resemblance to those detailed in Dr. Howard's case, which may, indeed, be taken as a standard of the extreme result which may thus be produced.

That it is a state beyond the remotest hope of the successful application of any curative means, when once it is established, is, I fear, but too clearly manifest. The suddenness with which, in many cases, it has been developed, and the all but total absence of premonitory symptoms, leave no room for therapeutic experiment of any kind.

You have, perhaps, left your patient the night before, to all appearance doing well, and when, on the third day or after, you approach him at your hour of visit, you are quite struck by a peculiar fœtor, which once perceived cannot be again mistaken; the pulse may be quiet, the countenance, perhaps, a little pale and anxious, and you are little prepared to find, when you turn down the bed-clothes, that the entire stump is, for many inches, it may be through more of the limb even, entirely dead and its tissues irreparably destroyed. A few hours more, and your patient, who was perhaps himself the least conscious of any danger, is a decomposing and disfigured corpse. As already observed, however, the clinical features are very various. Those I have here attempted to describe are drawn from the phenomena presented in the cases of some of the most stalwart grenadiers and artillerymen that could adorn any army, many of them, too, our own countrymen, who succumbed after operations in the middle and upper third of the thigh on the third or fourth day, from the effects of this truly awful form of disease.

Trusting you will excuse this long trespass on your space,

I am, Sir,
Very faithfully yours,
Robert D. Lyons,
Pathologist to the Army in the East.

Bibliography.

Die Lehre vom Auswurf. Von Dr. Anton Biermer, Vormals Assistenzarzt der Medicin, Klinik am Juliusspitale zu Wurzburg.

(*Concluded from page* 320.)

Dr. Biermer's investigations on the subject of the presence of elastic fibres in the sputa do not point to similar results as those arrived at by Remak. He did not in the first place find the elastic fibres nearly so frequent a constituent of tubercular expectoration, albeit he examined a vast number of specimens of tubercular sputa with the utmost care; nor could he derive from their presence the minute knowledge as to the pathological state of the lungs which Remak had done.

Respecting the mode of examination, Dr. Biermer says, the elastic fibres are to be sought in muco-purulent sputa, presenting grey spots or filaments. The sputum of the spitting vessel should not be selected, but the patient should be directed to expectorate three or four times on paper or on a plate.

As to the *diagnostic value* of these elastic fibres in the sputa, Dr. Biermer considers their presence at an early stage of pulmonary disease, when there are no other signs of organic change, as pathognomonic of commencing phthisis.

At a later period, especially when satisfactory signs derived from percussion and auscultation may be absent, the elastic fibres may be considered as indicating with tolerable certainty destruction of tissue and the formation of a cavern. Again, the absence of expectoration containing elastic fibres may give reason to hope, that healing of the cavern is in process.

Wedl, in speaking of the contents of tubercular caverns, says:—"When the organic detritus is not so completely disintegrated, detached pulmonary fibres may be seen in the pultacious contents of the cavern, and may be readily recognized by the peculiar way in which they are curved. These fragments should be looked for in the sputa of phthisical patients, and are of diagnostic importance, as indicating a loss of substance in the pulmonary parenchyma."

According to Schröder van der Kolk, they are more likely to be met with in the sputa in cases when small caverns exist in a state of progressive development, than where large ones are present, in the advanced state of phthisis.

We have directed attention particularly to this subject, inasmuch as it is untouched upon in the ordinary standard works on thoracic disease, to which the English student has access.* Even Louis in his great work on phthisis, does not allude to the fact of fragments of lung and tissue being found in the sputa of the phthisical. If we needed a proof of the importance of an accurate examination of the sputa, we have it in a statement of Louis, who informs us that in two very remarkable cases, M. Chomel and he were led to recognize the tubercular disease by the globular form of the sputa.

Cellular Tissue in the Expectoration.—Bühlman has observed cellular tissue in the sputa, but it is rarely met with. Dr. Biermer has seen it more than once in the expectoration of the tuberculous, and once in gangrene of the lung. In many cases in which it appeared in the sputa, he was doubtful whether it came from the respiratory organs, or was a residue of the food which had remained between the teeth, and became subsequently mixed with the sputum. The cellular tissue from the organs of respiration is generally known by its colour. It forms in the sputa small points or membranous shreds, opaque and of a dark grey colour. Microscopic examination exhibits an opaque amorphous tissue, in which black pigment granules are strewn in heaps. The addition of acetic acid renders it transparent. Dr. Biermer next adverts to the possibility of *muscular fibres* and *cartilage* being expectorated in ulcerative destruction of the bronchi or trachea. The presence of muscular fibres or of cartilage would, with all probability, enable us to infer that tubercular ulceration or wide extending syphilitic destruction existed.

Of plastic bronchitis Dr. Biermer gives an interesting notice. The earliest reference to the expectoration of bronchial polypi is found in the works of Galen. Dodonæus, Tulpius Bartholinus, and others among the older authors, have alluded to the expectoration of vessels, &c., which were, doubtless, what in after times have received the designation of bronchial polypi. Van Swieten says that the expectorated vessels of Tulpius were coagulated blood, which had assumed the form of the bronchi. To come to our own times, the first good description of the disease was published in the *Edinburgh Medical and Surgical Journal*, by the late Dr. Cheyne of this city; he subsequently, in his work on the Pathology of the Larynx and Bronchia, added to our knowledge on the subject. He has been followed by numerous contributors, and in the records of the Pathological Society of Dublin, and in the *Dublin Quarterly Journal*, may be found interesting communications from Sir Henry Marsh, Drs. Corrigan, Banks, and others. Dr. Biermer says the croupous inflammation of the bronchi may be idiopathic and independent, or may exist in complication with inflammation of the parenchyma of the lungs. According to the remarks of Remak, croupous pneumonia is frequent; this affection not often being present without minute casts of the tubes being discoverable in the sputa. This statement of Remak's is controverted by Zehetmeyer and Hœfle. In twenty-five cases of pneumonia in which they were sought for by Dr. Biermer, he was unable to discover their presence in six. Remak has stated that the bronchial concretions in the greater number of cases of pneumonia are present from the third to the seventh day of the disease, and in this statement Dr. Biermer coincides.

In chronic thoracic disease bronchial casts are also found in the expectoration; in many instances, however, in which polypi have been said to have been expectorated in phthisis, probably they were merely coagulated blood.

Laennec alludes to the presence of bronchial polypi in phthisis. He says:—"A toutes les époques de la maladie on distingue quelquefois dans les crachats des portions cylindriques et vermiculaires, qui paraissent avoir été moulées sur les petits rameaux bronchiques." Dr. Biermer says he can give no better description of the form, &c., of bronchial polypi than that of Remak, which he quotes. Great variety is observed in the size of the casts and the form they assume. The largest and most perfect specimen we have seen, presenting a cast of a bronchus of considerable size with those of numerous bronchules, was exhibited to the Pathological Society by Dr. Banks, who was indebted to Dr. Kelly, of Mullingar, for the opportunity of exhibiting it, and of reporting the history of the case.

The presence of crystals in the sputa is next considered by Dr. Biermer—of entozoa, of infusoria, and of fungi. We would gladly lay before our readers a more detailed account of Dr. Biermer's work on expectoration, of which we have given but an imperfect sketch, and that only of the first part, but our space does not admit of it.

The subject of expectoration is of great clinical importance, and we are bound, in all sincerity, to affirm, that Dr. Biermer has performed the task he assigned to himself with much ability, and that his labours have been crowned with high success. We do not know of any one treatise on expectoration which contains such an amount of information, or which will be found so valuable to the practical physician.

SELECTIONS FROM BRITISH AND FOREIGN JOURNALS, &c.

Sulphate of Quinidine in Intermittent Fever.

By C. B. Guthrie, M.D.

The thirteen cases here reported were treated with quinidine, the subsalt of the new Bogota bark, called by writers *China Bogotensis*. This new alkaloid differs from quinine, and has been esteemed as of less value in the treatment of periodic diseases. This bark is found in the province of Fusagasoga, some twenty-five miles from Bogota, and is generally recognized under the common name of Bogota bark, a name applied commercially to all barks from that region of South America, though including seven or eight varieties, many of which contain both quinine and cinchonine. These cases were reported by Dr. Foote, of Texas, who remarks:—"In none of the thirteen cases did I hear any complaint of its affecting the head unpleasantly, as quinine so often does, though in many instances given in larger does than we usually administer quinine." He also remarks that from the effects of the quinidine, as exhibited by the cases reported, we are bound to acknowledge its great antiperiodic power. The question with the medical profession is not alone whether quinidine has antiperiodic properties, but whether it has not this therapeutical effect without the disagreeable adjuvant found in the quinine, and also whether the use of this alkaloid, the product of a bark not monopolized by the English Government, may not be less expensive and quite as certain as quinine.—*New York Journal of Medicine.*

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*Professor Hughes Bennett of Edinburgh, in his Introduction to Clinical Medicine, in alluding to the presence of elastic and areolar tissue of the lung in the sputa makes the following important remarks:—"It is very possible that in doubtful cases, especially where, from chronic pleurisy or pneumonia, there is dulness, on percussion, whilst other signs are more or less obscure, the presence of these fragments will confirm a previous suspicion of existing phthisis."

Aromatic Syrup of Galls.

The following preparation has been considerably employed in Philadelphia; it is used in the diarrhœa of children:—

Take of galls powdered, half an ounce.
Cinnamon bruised.
Nutmegs bruised, of each two drachms.
French Brandy, half a pint.
Sugar in small lumps, two ounces (troy).

Macerate the solid ingredients in the brandy for twenty-four hours, throw into a filter, and when drained add diluted alcohol, until half a pint in all has passed. Having placed the tincture in a shallow capsule, suspend the sugar over it on a slip of woven iron wire, and then inflame the tincture, the flame proceeding from the burning alcohol fuses the sugar and scorches it so as to produce a portion of caromel, and as it melts it falls into and dissolves in the liquid beneath; when the combustion stops, the whole should be stirred and filtered for use.—*Amer. Jour. Pharmacy.*

Gastrotomy successfully performed in a Case of Internal Strangulation.

The case was as follows:—A man, 40 years of age, had had from infancy a reducible inguinal hernia in the left side. On the 7th of September, symptoms of strangulation appeared, but without the local signs of strangulated hernia.

12th September (seventh day), the patient was unrelieved; vomiting with constipation continued; the pulse was weak, and the patient greatly sunk; the abdomen was tense and tympanitic; the distended intestines formed prominent swellings. No trace of hernia existed in the inguinal region; the finger could be easily passed into the outer ring. After having been bled, the patient said the old hernial tumour had disappeared; internal strangulation was suspected, and gastrotomy was decided on.

The patient having been put under the influence of chloroform, M. Borelli cut transversely into the left iliac fossa, through the skin first, then through the muscles and peritoneum. A mass of large intestine protruded; no trace of strangulation existed, nor was any hernial sac to be found. The hand was introduced into the cavity of the abdomen, and at last a tight, hard ring was discerned, by which an intestine was strangulated. This was divided with a bistoury, (bistouri de Pott) the intestines replaced, and the wound closed by sutures, &c.

The operation lasted twenty minutes. Relief from vomiting was immediately obtained, but meteorismus and pain continued for two days without any alvine discharges. At last the bowels were freed. On the fourth day after the operation, the patient was twice blooded; on the fifth day, the bowels having been well freed, the patient was much better; his recovery was retarded by an attack of intermittent fever which yielded to quinine, and in the beginning of October he was quite well.—*Gazetta Medica Italiana.*

Injection of Iodine in Chronic Pericarditis.

The details of a case in which this proceeding was had recourse to, with apparent success, were recently published in this Journal. The case, which was originally published in the *Gazette Medicale*, is severely criticised by the editor of that journal, in a recent Number (No. 48, December 1st). The principal facts are briefly mentioned: the pericardium was tapped several times and iodine injected. After two relapses, and two injections, recourse is had to blisters over the pericardium. The effusion is absorbed. The writer then asks, whether the author of the paper (who belongs, he says, to a school which piques itself on great strictness in the observation of facts) has been sufficiently strict in the interpretation of facts in this case. The pericardium was twice tapped and twice filled again, in spite of iodine injections; then blisters are used, which possess an old reputation for promoting the absorption of similar effusions, and no hesitation is felt in ascribing to the iodine injections the benefit which most certainly was derived from the blisters!

This "little irregularity of reasoning," it is added, will not help to recommend the practice adopted.—*Gazette Medicale.*

On the Danger of Syncope during the Exhibition of Chloroform.

M. Gibert, Physician to the Hôpital Saint Louis, has recently addressed a letter to the editor of the *Gazette Medicale* on this subject. In his opinion it is useless for surgeons to continue to invent particular instruments and methods in order to diminish the danger of the inhalation of chloroform, since "the true and only danger in the administration of chloroform is *syncope*." When chloroformisation is necessarily prolonged, and the operation tedious, and accompanied with much hæmorrhage, the coincidence of syncope with all these depressing causes he conceives to be most dangerous. Contrary to the general rule of most surgeons, who would reserve the exhibition of chloroform for grave operations, and who reject it in slight operations, such as the extraction of teeth, the operation for phymosis, incisions, &c., M. Gibert says, that in these latter it may be employed without any scruple, as it is then almost always free from risk.

He fully agrees with Clements of Frankford (*Gazette Medicale*, Nov. 10, p. 712), that the danger of anæsthesia from chloroform lies in some nervous idiosyncrasy, owing to which syncope is developed.—*Gazette Medicale.*

Connexion between Bronzed Skin and Disease of the Supra-renal Capsules.

The "Medical Times and Gazette" remarks that the senior Physician of Guy's Hospital has recently added to the list of benefits which medical science has already received at his hands, by the publication of a monograph on the "Diseases of the Supra-renal Capsules." In this work, Dr. Addison, as probably most of our readers are aware, advances the opinion, that destructive disease of these hitherto little regarded organs is attended by most serious constitutional mischief. His views, which are, indeed, the simple expression of his clinical experience, and are supported by eleven carefully narrated cases, may be concisely expressed as follows: 1. That a peculiar browning or bronzing of the skin is indicative of disease of the supra-renal capsules. 2. That it may depend on any disease which affects the disorganization of these bodies, *e. g.*, cancer, tubercle, abscess. 3. That patients suffering from this symptom fall gradually, and without obvious cause, into a peculiar form of debility, which results almost invariably in death within a limited period. 4. This form of debility is rarely attended by much emaciation, and the subject of it, although with much flabbiness of tissue, retains throughout a general bulkiness of frame, which contrasts strongly with his extreme feebleness. 5. That, usually, no other important visceral complication supervenes.

Should these conclusions prove to be correct, it will be seen that we have an important and well-characterized disease added to the nosological list. Here is a train of peculiar symptoms and events originating in a morbid state of an organ, of the pathology of which, hitherto, nothing has been known, and whose functions, whatever they may be, have been deemed of but little importance. Dr. Addison's facts are as yet only eleven in number, and, although they all support the conclusions indicated, yet that they are not sufficient data to set at rest so important a question few, we suspect, would be found more willing to admit than himself. It now rests with the Profession at large to pursue the inquiry; and, should that be done with the same candour, zeal, and energy with which he has opened it, it will not be long before the requisite data are in existence. During the last few years, several cases have occurred in different metropolitan hospitals, having more or less similarity to those described, and which the "Medical Times and Gazette" are now engaged in grouping together.

Case of Aneurism of the Ophthalmic Artery, and of its principal Branches, cured by Injections of the Perchloride of Iron.

This case, which was treated by M. Bourguet of Aix, is one of much interest. The tumour appears to have been an *aneurismal varix* (*arterial varix* of Dupuytren; *cirsoid aneurism* of Breschet). The influence of the per-chloride of iron in effecting the consolidation of such a tumour is well illustrated; and we learn that this agent, first employed by Pravaz, is as applicable to the treatment of varix, as of the other forms of aneurism.*

The case detailed by M. Bourguet is that of a girl, thirteen years of age, in whom an aneurismal tumour formed in the right orbit, six months after a severe fall from a window, which inflicted several severe contusions. The first evidence of the disease in the orbit was the protrusion of the eyeball, and then a pulsatile tumour appeared internally, opposite the lachrymal sac. The tumour gradually enlarging, extended to the forehead, to the side of the nose, and into the upper eyelid. The case came under M. Bourguet's notice, December 27, 1854. At that time a series of tumours, pulsatile, soft, and elastic, existed at the inner side of the orbit, extending in the directions above mentioned: that portion over the forehead was oval, and about as large as an almond; it reached to the middle line, and inferiorly became confounded with the mass in the orbit. The orbital tumour was as large as a pigeon's egg. The tumour in the upper eyelid was of a cylindrical form, and seemed to be formed of a number of flexuous, twisted vessels. All these tumours were the seat of a vibratory *frémissement*, and yielded distinct pulsations, isochronous with the pulse in other arteries, and ceasing when the carotid was compressed; a distinct *bruit de souffle* was audible. The integuments over some portions of the tumour were very thin, and of a blueish tinge. Direct pressure lessened the size of the tumours; but when the pressure was removed, the vessels quickly refilled. Compression of the carotid, as was mentioned, at first arrested the pulsations; but after a while these would reappear, owing to the blood getting round by the vertebral arteries, [and, it might have been added, by the carotid of the opposite side.—*Trans.*]

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* For an account of this mode of treating aneurism see the DUBLIN HOSPITAL GAZETTE, vol. i. p. 137.

"Beside these tumours," says the author, "which were evidently formed by a considerable dilatation of the nasal, frontal, and superior palpebral branches of the ophthalmic artery, the trunk of the artery itself would appear to have been aneurismatic." This opinion was founded on the existence of protrusion of the eyeball; by pressure the globe could be replaced in the orbit; but it quickly became dislodged when pressure was removed; vision was lost of that eye, and in the corresponding side of the head, as well as in the eye, the patient complained of the most painful sensations of throbbing, &c. Treatment by *electro-puncture* was first employed, and was repeated on four occasions, without any benefit having been derived. Its employment seems to have caused great pain.

February 28.—Injection of the perchloride of iron was used: the carotid having been compressed, the trocar of M. Charriere was introduced into the frontal portion of the tumour, and the syringe having been adapted, six or seven drops of the solution (twenty-eight degrees of strength) were injected: all pulsation ceased in the neighbourhood of the canula—pressure was maintained on the carotid for about twenty minutes—nothing unpleasant followed.

March 1.—The operation was repeated in the orbital portion of the tumour; the canula was on this occasion introduced deeply, and seventeen or eighteen drops of the solution were injected, *care being taken to disseminate the fluid in different directions*, so as to multiply the points of contact, and at the same time prevent too intense inflammation by an excess of the fluid at any one point. Much of the tumour now became solidified; some nausea followed, with slight vomiting in the course of the day. On the next day the patient felt well,—the orbital and frontal tumours were quite firm, and free from pulsation. There was ecchymosis of the eyelids.

March 6.—The tumour of the eyelid is gradually becoming solid; the eyeball is less prominent.

A fortnight after the operation all pulsation had ceased, and the patient was free from every uneasy or painful sensation. Ten months afterwards, "the cure was as perfect as could be desired," the tumours had disappeared, the eyeball was replaced in the orbit, and vision was completely restored.—*Gazette Medicale.*

OBITUARY.

On 1st December, of Spasmodic Cholera, at Beicos Bay, off Constantinople, Dr. John A. Corbett, Surgeon of H.M.S. St. Jean D'Acre, late surgeon of the Miranda, aged 38 years.

Dr. J. A. Corbett entered the Naval Service in 1840, and served with distinction during the war with China, in North Australia, Coast of Africa, in the Baltic and White Sea expeditions, and lastly in the Black Sea Fleet.

Death of Dr. Chambers.—This distinguished Physician, whose death we announce in our columns this day, was born in India, in the year 1786. He was descended from an old family, long resident in the county of Durham, and was related to Sir Robert Chambers, Chief Justice of Bengal; Sir Charles Chambers, Judge of the Supreme Court of Bombay; Lord Glenelg, and Sir Robert Grant. Dr. Chambers was the son of William Chambers, Esq., in the civil service of the East India Company, and a distinguished Oriental scholar; his mother was the daughter of Thomas Fraser, of Balmain. He came to England in 1798, was educated at Westminster School, and afterwards became a student at Trinity College, Cambridge. His professional studies were conducted at the Windmill-street School of Medicine, and at St. George's Hospital. In 1816, when only thirty years of age, Dr. Chambers was appointed full Physician to the latter establishment. In 1820, he married his first cousin, Mary Fraser, by whom he had two sons and two daughters, all living. Soon after this period his practice rapidly increased, and he is well known to have held for many years the first rank as a Physician in this Metropolis. In 1837, he was gazetted as a Physician to His Majesty William IV., who created him a K.C.H., but he is said to have declined adopting the usual title of knighthood, for reasons which have not been explained, but which were no doubt satisfactory to his own high sense of honour. In the year 1848, he experienced a severe attack of illness, marked by symptoms of disordered circulation in the head, accompanied by occasional epileptic fits, and partial palsy of the right hand, leg, and right half of the tongue. This visitation induced him to retire almost wholly from practice, and it was hoped that his health, which had always been delicate, would be restored by repose from the arduous duties of professional life. Such, however, was not the case, for, after his retirement, the unfavourable symptoms continued to increase, so that walking was attended with great difficulty, and even conversation was carried on by him with extreme labour. At the commencement of last week, he was observed to be much better than usual, and conversed with unwonted ease about the subject of some books which were read to him. This improvement was attributed to the pleasure which he experienced in seeing all his family around him on the occasion of the marriage of his youngest son. But the transient amelioration of his symptoms was followed by an aggravation of the tendency to serous effusion on the brain, which he had previously manifested, and a fatal termination was indicated by the occurrence of vomiting and stupor, rapidly followed by complete coma; and he died without pain or convulsion, on Sunday, Dec. 16, aged 69.—*Medical Times and Gazette.*

TRANSMISSION OF NEWSPAPERS.

General Post Office,
26*th December*, 1855.

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I am, Sir, your obedient Servant,
ROWLAND HILL, *Secretary.*

DUBLIN: PUBLISHED BY W. B. KELLY,
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LONDON: S. HIGHLEY, 32, Fleet-street.
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DR. SHERIDAN MUSPRATT, F.R.S.E., M.R.I.A.,

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PUBLISHED ON THE 1st AND 15th OF EACH MONTH.

SENT FREE BY POST.

Annual Subscription, 10s.; Half-yearly, 5s.; payable in Advance.

THE
Dublin Hospital Gazette.

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No. 24.—Vol. II. JANUARY 15, 1856. Price 5d.

Lectures on Diseases of the Stomach.

BY DR. LEES,

PHYSICIAN TO THE MEATH HOSPITAL, LECTURER ON PRACTICE OF MEDICINE.

No. V.—*Catarrh of the Stomach; in Drunkards; Treatment.*

Dr. Budd, in his lectures on diseases of the stomach, has described another form of inflammation, which may be also included under the head of chronic, and in which coagulable lymph becomes effused into the cellular tissue under the mucous coat, which coagulable lymph, if not soon absorbed, hardens and contracts, forming a dense gristly tissue, binding the mucous membrane to the coats beneath. Inflammation causing this result frequently occurs at the margin of a chronic ulcer of the stomach, but it often exists also, especially in the neighbourhood of the pylorus, independently of ulceration, or any other permanent change of texture in the mucous membrane. In such cases, the lymph is generally effused pretty evenly about the pylorus and leads to the formation of a gristly ring or band, which, by its contraction, permanently narrows the orifice. He states that this form of disease seldom occurs till near the age of forty, and is almost invariably the result of intemperance in drunkards; in these cases, the pyloric orifice becomes gradually narrower, and the action of the muscular fibres near this part is impeded, so that the stomach seldom empties itself completely, and the acid residue of digestion in it ferments, causing heartburn, sour eructations, flatulence, and vomiting. The stomach continues to grow larger, and as its capacity augments, the vomiting may become less frequent, though a greater quantity is thrown up at a time, and eventually the disease destroys life by impeding the passage of food into the intestine. This disease has been mistaken for carcinoma, as it produces similar symptoms to those of cancer of the pylorus, but is distinguished from it by its slow progress, by the absence of hæmorrhage, which frequently occurs in cancer, by there not being any perceptible tumour, and by its not having a tendency to disseminate itself and infect neighbouring parts. In the early stage of this disease our treatment should be directed to reduce inflammation, and promote the absorption of effused lymph, leeching, the cautious administration of mercury, followed by iodide of potassium, and counter-irritation will promote those objects, but the proper regulation of diet, and the giving up of intemperate habits, is of the greatest importance towards insuring a complete recovery.

Under the head of chronic gastritis, we may consider an affection of the stomach which has been denominated gastrorrhœa, and is characterized by the copious vomiting of a clear, glairy fluid, usually insipid, resembling in appearance the uncoagulated white of eggs, or simple mucus; the discharge occurs most frequently in the morning fasting, but may take place at any time, and it is a curious fact, that this fluid is often thrown up after meals, without a simultaneous discharge of food from the stomach. Andral has recorded the case of a woman who vomited every day about four pints of this glairy fluid, and yet, never discharged either food or drink; on dissection there was a general thickened state of the mucous membrane of the stomach, which was of a brownish colour, and the follicles were remarkably developed. This condition appears to depend on a catarrhal state of the stomach, and though it may occur under the same influences as ordinary catarrh of the bronchial mucous membrane or conjunctivitis, yet it is more frequently observed as a consequence of congestive disease of the portal system. The mucous membrane becomes congested, presents a swollen, œdematous, or granular appearance, and is covered with a thick tenacious layer of mucus, which is sometimes found to be alkaline in its reaction, is with difficulty washed off by water, and consists of mucus-corpuscles, nuclei, and epithelium; Dr. Jones considers this fluid to be analogous to the secretion of mucus which takes place in ordinary catarrh; but I think that it is chiefly connected with a disordered condition of the mucous follicles, which relieve themselves by a copious exudation of mucus; it is a troublesome form of disease, but seldom fatal, unless in old persons, when the pyloric region is the part found to be chiefly affected. The chief symptoms complained of are, a total want of appetite, a sense of weight and distention in the epigastric region after taking the smallest quantity of food, pain between the shoulders, occasional vomiting, constipation, the tongue is coated with a thick layer of white mucus, there is a constant bad taste in the mouth, the patients suffer from acrid flatulent eructations, cold feet, and a languid circulation.

This disease is often met with in drunkards, and is then generally associated with the disturbance of the nervous system, induced by hard living, and characterized by sleeplessness, or sleep disturbed by uneasy dreams, a wretched feeling of exhaustion in the morning, and a tremulous state of the hands and tongue. Similar symptoms may, however, occur in persons of temperate habits; but whose nervous systems are exhausted by mental anxiety, want of sleep, or deficiency of food, as these influences will cause hallucinations, tremor of the hands and tongue, total loss of appetite, and vomiting, just as much as the intemperate use of spirits. This affection is also common among the women of large towns, who are overworked, badly fed, and often addicted to intemperance.

In the treatment of this disease, you must first remove the exciting cause, make them renounce intemperate or irregular habits, adopt a regular and nutritious diet, take every morning, fasting, a small tumbler of cold water, or tepid, if it is more agreeable, and follow that, after about half an hour, with an ounce of infusion of gentian, quassia, chiretta, or columbo, which may be taken with a drachm of tincture of the same two or three times a day, a short time before meals. As there is generally much bilious congestion, with constipation and flatulence, give five grains of inspissated ox-gall, with three of extract of rhubarb, and three of compound galbanum pill at night. Opium is one of the most efficient remedies in this disease, as the appetite generally returns when the nervous system has been refreshed by sleep; so the best way to give it is in a full dose at night. I have used the tinctura cannabis indicæ, combined with aromatic spirit of ammonia, in one case, with benefit, where it not only corrected the irritability of the stomach, but also allayed the wretched sinking sensation which the drunkard suffered from when deprived of his habitual stimulus. In all these cases you must make them take solid nourishing food, for no medicines can have any good and permanent effect till the stomach is able to digest solid food. Dr. Osborne, in his "Propositions on Diseases of the Stomach," published in the *Dublin Medical Journal*, makes some good observations on the diet and medicines suited to these diseases. He advises, "when meats are taken, they should be such as are most free from osmazome, as chickens, rabbits, sheep's trotters, &c., and should always be accompanied by boiled rice or other vegetable matter, in order to diminish the stimulating effect;" he also recommends the use of yolk of eggs, and cites a case of vomiting from a congested state of the stomach in the last stage of diseased mitral valve, in which great relief followed its use. He lays great stress on "dilution of the contents of the stomach," as he considers that the mucus is dissolved, and so renders the membrane accessible to astringent remedies; and he thus explains the efficacy of mineral waters in irritability and chronic inflammation of the stomach, as when an invalid at one of the spas drinks six or eight beakers of water before breakfast, and walks in the intervals, he washes out the mucus, and then the small proportion of salts held in solution acts on the membrane as sedative and astringent.

He advises that the patient should drink a tumbler of tepid water on an empty stomach, and use a little gentle exercise before taking his medicine, which ought to consist of astringents in sedative doses, such as the acetate of lead in solution, in doses of one or two grains, three times a day, to which may be added acetate of morphia if there be excessive secretion of sour fluid. Sulphate of zinc is useful in very chronic cases, also the mineral acids, and my friend, Dr. Hudson, tells me that he has used sulphate of alum in doses of ten grains with much success. The flower of mustard, simply mixed up with water, applied on a cloth, and suffered to remain on till smarting is produced, is a powerful adjuvant, interferes with no other remedy, requires no dressing except dry lint or wadding, and may be used every evening on going to bed.

Nitrate of bismuth is a medicine which is very efficacious when the stomach secretes an unhealthy mucus, or when there is an excessive or untimely secretion of gastric juice, which is often met with in connexion with tubercular disease of the lungs, and also in infants when vomiting with exhausting diarrhœa results from the irritation of teething, or the use of improper food, or from the change of diet on weaning, the "weaning brash" of some writers, which is in many cases a gastro-enteritis. Bismuth appears to exercise a peculiar action on the mucous membrane with which it is brought in contact, restrains undue secretion, and has a sedative influence on the stomach, both by its direct action on the mucous membrane, as well as by modifying the excessive secretion of irritating fluids. The best way to give it is in water, lime-water, or milk, a short time before meals. Three, five, or ten grains, three times a day, is quite sufficient. It appears to soothe the mucous membrane over which it passes, and has little effect on the general system, except indirectly from the action it exerts on the stomach. It may, however, be advantageously combined with other medicines, which tend to assist its action, as prussic acid, opium, magnesia, or chalk. I have found its combination with dilute hydrocyanic acid of great use in allaying the morbid irritability of the stomach, which occasionally complicates acute inflammatory affections of the chest, and renders the convalescence tedious and dangerous. These patients sometimes suffer from constant nausea, great thirst for cold drinks, and vomiting, not only of food and drink, but also of quantities of very sour fluid, which often exceeds in amount the proportion of fluids actually swallowed. In such cases I am in the habit of prescribing a scruple of bismuth with twelve drops of dilute hydrocyanic acid, in six or eight ounces of either water, lime-water if there be diarrhœa, or in the solution of magnesia if the bowels are confined. Of this mixture an ounce, three or four times a day, will generally allay all the distressing symptoms, and improve the appetite and digestion.

CASE OF THORACIC ANEURISM ASCENDING INTO THE NECK, WITH PERMANENT CONTRACTION OF THE PUPIL OF THE LEFT EYE.

BY JOHN T. BANKS M.D.,

KING'S PROFESSOR OF PHYSIC, PHYSICIAN TO THE WHITWORTH AND HARDWICKE HOSPITALS.

The case which I am about to detail is one which presents a feature of great clinical interest, and which, from its extreme rarity, is worthy of being placed on record, and added to the two previously reported examples of aneurism, in which the phenomenon of contracted pupil has been noticed in connexion with the disease. That the state of the pupil existing in this case must be of very unusual occurrence, may be inferred from the absence of any mention of it in the works of many writers who have so largely contributed to our knowledge on the subject of cardiac and arterial disease. I was not myself aware that contracted pupil had ever been remarked under similar circumstances to those in the case about to be narrated, until my attention was attracted to a communication from my friend Dr. Gairdner, in the August number of the "Edinburgh Journal," a periodical the pages of which are frequently enriched by highly valuable communications from the pen of this distinguished physician.

The case, in which this condition of the pupil was observed by Dr. Gairdner, was one of aneurism of the aorta projecting into the neck: he observes that it is "an interesting example of a pathological condition explicable by physiological laws."

Dr. Gairdner refers to the researches of Dr. John Reid on the vagus nerve, and also to the experiments of Valentin, and comes to the conclusion that these investigations are clearly applicable to the explanation of the case he communicates. According to Valentin, the iris is furnished with nerves from two sources. The section of the sympathetic trunk in the neck paralyses the nerves which act on the radiating fibres of the iris, from the spinal system *through the sympathetic*, and resigns the pupil to the exclusive influence of the circular fibres, or those which contract the pupil, and which are supplied from the inferior branch of the motor oculi nerve, and thus the pupil is kept permanently contracted. Budge and Waller's experiments are confirmatory of Valentin's views.

Stimulating the sympathetic in the neck dilates the pupil, and cutting it causes contraction of the pupil more or less permanent.

It appears that the records of medicine present only one case of aneurism, in which contracted pupil had been noted, previous to the case described by Dr. Gairdner. In the year 1838, Mr. Hare, the house-surgeon of the Stafford Infirmary, published, in the "Medical Gazette," a report of a case in which a scirrhous tumour, occupying the inferior triangular space on the left side of the neck, was accompanied by a *contracted state* of the pupil. On dissection, after death, it was found that the pneumogastric, phrenic, and *sympathetic* had passed into its substance, and were transformed into diseased structure.

Dr. Gairdner refers to a case of aneurism at the root of the neck, noted by Dr. Walshe, in which the pupil was observed to be "very notably smaller than the other."

A. F., a woman aged 24 years, was admitted into the Whitworth Hospital on the 27th of November, 1855. She stated she was a married woman and had four children, and it was afterwards ascertained that she was a person of dissolute and highly intemperate habits. She was rather delicate in appearance, and of slender form; but she said her health was perfectly good until twelve months before her admission into hospital. At this period she received severe injuries from blows inflicted by her husband. Her lower jaw was broken, and she fell heavily on her left shoulder. For some time after she experienced pain in the side of the neck and point of the shoulder, slight at first, but gradually becoming more severe, and causing her to lean to the left side.

The complaint for which she sought admission was bronchitis. Her breathing, she informed us, had been for a considerable time short, more especially on making any unusual exertion, but it had recently become more oppressed, and the cough had been accompanied by stridor. Aphonia did not exist. On proceeding to examine her chest the following condition of parts was observed:—There was an obvious prominence, involving the left clavicular region, extending beyond the median line, and also above the clavicle, the sternal end of which was displaced forwards, and a little upwards. The superficial veins were enlarged over the infra-clavicular region. The jugular vein at the left side was also larger than the right. An impulse is visible at the upper sternal and sub-clavicular regions. The sternal half of the clavicle is dull on percussion, as is also the infra-clavicular region, to an extent of two inches beneath the bone at its sternal end. The upper third of the sternum is also dull, and over the tumour percussion gives a sensation of abnormal resistance. With regard to the acoustic phenomena, two sounds are audible in the same situation, resembling the cardiac sounds, but being less clear. Neither sound approaches in the least to the character of a murmur. No pulsation can be discovered in the left carotid, and the radial pulse is absent. The respiratory murmur is decidedly more feeble over the left lung than the right.

Pain was experienced in the seat of the aneurismal tumour, and it extended along the inside of the arm to the ring and little finger. The arm was also numb and colder than the right arm; there had never been œdema. The first time this patient was seen by me, I remarked that the left eye was smaller than the right, and upon examination of the eye, I noticed also that the left pupil was smaller than the right. This condition of the pupil was constant, I mean its being always relatively smaller; it was susceptible of change, however; but in strong light, or in shade, the relation between the two pupils continued the same. The sight of the left eye was as good as that of the right. I repeatedly and most minutely made the eye the subject of investigation, and I called the attention of my clinical class to this singular phenomenon. I had intended to have made some observations on the effect of atropine on the eye, but I failed in my endeavour to induce the patient to remain in hospital, after she experienced relief from the symptoms for which she sought admission originally. At some future time I may be enabled to communicate the sequel of this highly interesting case; meantime I considered the case, incomplete as it is, worthy of publication, for taken in connexion with Dr. Gairdner's case and the other, it may aid "in fixing the attention of physicians on the state of the pupil in similar cases of disease." To Dr. Gairdner is due the merit of bringing the contracted state of the pupil, as a result of pressure produced by aneurismal tumours on the nerves, in a prominent manner before the profession, and thus in his own words he has "indicated a new source of functional disturbance in thoracic aneurism, as connected with the interference of such tumours with the nervous system."

In conclusion, I may refer to the fact not observed in the former cases, namely, that in the case under consideration, not only was there contraction of the pupil, but the eye itself was considerably smaller than the other.

ON SOME POINTS IN THE PATHOLOGY AND DIAGNOSIS OF URINARY DISEASES.

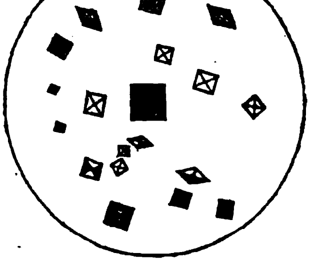
BY B. WILLS RICHARDSON, F.R.C.S.I.

(*Continued from page* 261.)

Oxaluria; Saccharine Urine of low specific Gravity.

At page 152 of the present volume of the Hospital Gazette, I published a case of Oxaluria, in which the patient was remarkably free from the severe constitutional disturbance so frequently accompanying the presence of oxalate of lime in the urine. I recently met with this salt (fig. 1.) in the urine of a young girl but two years of age, and in her case it was apparently attributable to disturbance of the assimilating functions, resulting perhaps from the irritation of dentition. She was rather irritable, and was affected with diarrhœa. These symptoms, however, were

Fig. 1.



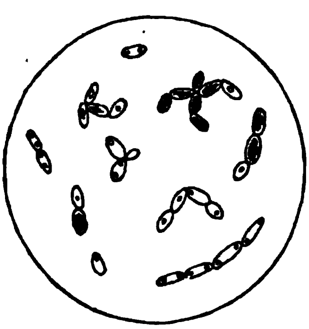
slight, and of but short duration, and I may say that they disappeared almost without treatment. I cannot bring to my recollection ever having seen a specimen of urine so loaded with oxalate of lime as was that of this patient. Dr. Lionel Beale* has alluded to the case of a child also two years of age, who was affected with jaundice, and in whose urine the dumb-bell crystals were found. I have hinted at this case, because it is of considerable interest from the coincidence of the jaundice, and the presence of oxalurate of lime (?) in the urine:† the presence of oxalate of lime in the urine, in cases of jaundice, being suspected by Dr. Budd‡ to be an important indication of jaundice arising from suppressed secretion of bile, and which is so frequently fatal with severe head symptoms. Dr. Beale, owing to the character of his work, does not give us any further information as to the case, which is to be regretted for the above reasons.

As far as my experience at present has gone, it tends to corroborate the assertion of the late Dr. Golding Bird, as to the great frequency of oxalate of lime in the urine; indeed, I have a friend at the present moment, in whose urine the slightest irregularity in diet, or anxiety of mind, causes its appearance, but it rapidly vanishes on correcting his diet, and when he is freed from mental disturbance.

I lately had an opportunity of examining a specimen of urine, which presented one or two points of interest. I cannot give the particulars of the case, as it was sent to me through a third party to examine.

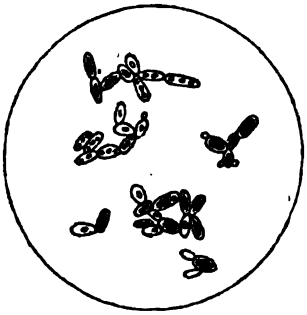
In the first place it was saccharine, but the quantity of sugar present was not sufficient to affect its specific gravity, being as low as 1·017.

Fig. 2.



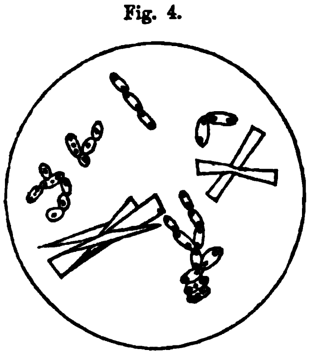
Saccharine urine of low specific gravity has also occasionally been met with by some of our most eminent writers on urinary pathology, for instance, Bouchardat, according to Becquerel,* has found it of spec. grav. 1·020; and Dr. Prout in his memoir on diabetes,† states that he has once or twice seen the specific gravity of saccharine urine as low as 1·015; finally Dr. Golding Bird‡ in speaking of torulæ, mentions that they may appear in urine which "contains but very small portions of sugar, too little even to affect its specific gravity materially, or to cause it to assume a diabetic character." In addition to the low specific gravity, the specimen of urine above mentioned contained a large quantity of torulæ§ in different stages of development (figs. 2, 3, 4, and 5), from the sporule to the thallus, and a few crystals of uric acid (fig. 4). It was free from albumen.

Fig. 3.



The tests I had recourse to in examining the urine were Moore's, Trommer's, and Maumene's. It may seem superfluous to say anything here relative to the mode of applying these, but still I venture to do so, because there is some nicety required in applying the tests of the two latter gentlemen. In case, for instance, we meet with a specimen of urine containing torulæ, and of a low specific gravity, as in the above one, it will be at once evident that the quantity of sugar present cannot be considerable.

Fig. 4.



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* The Microscope, and its application to Clinical Medicine, page 217. London, 1854.

† The affinity between the dumb-bell and octohedral crystals is evident from the fact, that if the first are kept in liquid for some time, they change into octohedra.—Bowman, "Medical Chemistry," page 58. London. 1855.

‡ Diseases of the Liver. London. Second Edition. p. 280.

* Séméiotique Des Urines, Paris, 1841, p. 488.

† Stomach and Urinary Diseases, 3rd Ed., London, p. 26.

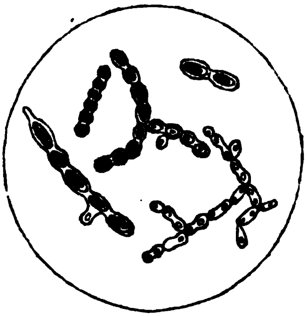
‡ Urinary Deposits, 4th Ed. London, p. 864.

§ I believe it was Quevenne who first mentioned these bodies, and their influence in exciting fermentation. Becquerel.—Ibid. p. 488. Rayer Maladies des Reins, T. i. p. 215.

In using Trommer's test, therefore, we must not add much of the solution of sulphate of copper; in fact, the urine should be barely coloured with it, because—for the reason mentioned by Mr. Bowman*—if too much of the sulphate of copper is added, the suboxide of copper "might be mixed with the black oxide (the sugar being capable of reducing only a certain definite quantity), which would, more or less, mask the characteristic colour and appearance of the suboxide."

There is a discrepancy between Heller's reading of Trommer's directions for using his test, and the translations of them by the generality of writers on urinary pathology, the former writer stating that Trommer's directions are, to "add a solution of sulphate of copper to the urine in a test tube, until an intensely green colour is obtained."† I think, however, for the reason above given, that Dr. G. Bird's and Mr. Bowman's directions are the best to follow, particularly if we have only a small quantity of urine to operate on.

Fig. 5.



Perhaps it would be better for those who are not in the habit of pursuing investigations of this kind to try Kletzinsky's fluid‡ (composed of potash, glycerine, and saturated solution of sulphate of copper); I have used this test within the last few days, with some diabetic urine (specific gravity, 1.045), from a patient under the care of Dr. Law, and found it both convenient and easy of application. On adding a few drops of the fluid to the diabetic urine in a test tube, and boiling the mixture, it became of an opaque amber colour, with a tint of orange red by transmitted light, but on mixing nearly equal parts of it and the diabetic urine, and then boiling, the reduction of the copper was rapidly effected, but it had not the intense red cupreous colour of the deposit caused by Trommer's test with another portion of the same urine. On boiling some of Kletzinsky's fluid with non-saccharine urine, a whitish flocculent deposit makes its appearance in the blue solution, which has a slightly olive colour by transmitted light.

There is another test (Maumene's) relative to which I wish to say a few words. This test is founded on the circumstances of the power of sugar, in reducing the salts of tin, or, as Mr. Bowman explains it, the "sugar is decomposed, and a brownish black compound, resembling caramel, is produced."* Narrow slips of white merino, or any other *woollen* tissue, are soaked in a solution of bichloride of tin, and then carefully dried in a water bath. Now, if we are not most careful in applying these test-cloths, for the detection of sugar, they may lead to error. This is owing to the readiness with which white woollen textures scorch, and thus become of a brownish black colour, when there is no sugar whatsoever in the question.

The pieces of white merino, after being saturated with the suspected urine, should be also dried in a water bath, for if held over a lamp, or before a fire, it will be difficult to avoid the scorching, as just mentioned. If sugar be present, the test cloth will become of a dark brownish, almost black colour. When carefully applied this is a very accurate test for sugar, but in my hands it was not so delicate as I was at first led to expect, M. Maumene having stated that the prepared merino will detect the traces of sugar in a mixture composed of ten drops of diabetic urine and half a pint of water, for I found that a mixture of one drachm of the diabetic urine (Dr. Law's specimen) and two ounces of distilled water gave no evidence of the presence of sugar with the prepared merino, and it was not until I had arrived at the proportion of two drachms of this urine to the same quantity of water, that there were any indications of the presence of sugar, but, of course, not to the same extent as the undiluted urine. Let it be understood that I am not so presumptuous as to imagine that I may not have erred in my manipulation of Maumene's test. I took every precaution, however, to avoid error, and I procured the bichloride of tin at one of the most respectable pharmaceutical houses in this city.

It is of importance, as Mr. Bowman mentions,* not to use either cotton or linen for Maumene's test, because these substances being analogous to sugar in composition, are similarly decomposed when warmed with the bichloride of tin.

In testing the specific gravity of urine, it is necessary to see that the urinometer is accurate. These instruments are often very incorrect, so much so as to give rise to an error of eight or ten degrees in the reading. Dr. Beale† has drawn attention to this point; according to this gentleman the "degrees marked upon the stem should gradually diminish in length from above downwards. If they are equal, the instrument may at once be pronounced as incorrect, without resorting to an experiment." I have myself seen urinometers, so graduated, give an error of five degrees in the reading.

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* Medical Chemistry. London, 1855. 3rd Ed. Page 40.

† *Vide* Dr. W. Moore's recent translation of Heller's Pathological Chemistry of the Urine. Dublin: 1855. Page 39.

‡ Heller. Ibid. Page 39.

* Heller. Ibid. Page 40.

† Ibid. Page 245.

Since the foregoing was put in type I have seen Dr. Hassal's interesting paper on the development of torulæ in urine. From his investigations, it appears that two different species of fungus may be met with in the urine. One resembles the Penicilium glaucum, and the other is the true sugar fungus, and is identical with the Torula cerevisæ, or yeast plant. The Penicilium may be developed in either non-saccharine or saccharine urine, but the latter only occurs in urine containing sugar. They may, however, co-exist in the same saccharine urine. The Penicilium is frequently seen in acid albuminous urine.

For further information on this point I must refer to Dr. Hassal's memoir, in the thirty-sixth volume of the "Medico-Chirurgical Transactions."

Case of Compound Comminuted Fracture of the Hand with Remarks.

BY T. C. SHINKWIN, M.B.,

DEMONSTRATOR OF ANATOMY, QUEEN'S COLLEGE, CORK.

Henry B——, ætat. 50, of a thin, spare habit of body, was admitted into the South Infirmary, Cork, on the morning of the 15th May, 1855, with severe injury of the hand.

He states, that whilst in the act of sharpening a circular saw, the sleeve of his coat was caught, and his hand and arm carried round by the saw before he had power to stop it. He had to travel about six miles to come to hospital, and arrived so exhausted, as to require the administration of some slight stimulants before the coverings could be removed from the hand; it was then discovered that there was a compound comminuted fracture of the first, second, and third metacarpal bones, with dislocation of the scaphoid and lunar from the radius, thereby opening the wrist joint, and causing terrible laceration of the flexor and extensor tendons of the hand. There was no hæmorrhage of any consequence.

After a consultation being held, at which the question was raised, whether or not Dr. Tanner ought to perform partial amputation, and try to save the little and ring fingers; it was deemed more prudent to amputate at the fore-arm, which was performed by Dr. Tanner about three inches above the joint. The operation was done quickly, and so much had the man rallied from the first shock, that he was able to walk from the operation room to his ward without assistance. The parts healed very kindly, and in a short time the man was dismissed cured.

Remarks.—It was rather a nice point to decide in the present day, when conservative surgery is so much thought of, whether in this case partial amputation of the hand ought to be performed. Such an operation, we think, would have at once deprived the patient of all hope of recovery; for when we consider his advanced age—the extent and severity of the laceration, tearing, as it did, all the extensors of the thumb, laying open the wrist joint, dislocating the two carpal bones entering into its formation, and also completely dividing the radial tendon of the common extensor—the amount of suppuration sure to follow such an injury—and last of all the danger of tetanus,—we must come to the conclusion that partial amputation would most likely have been succeeded by fatal consequences.

But suppose Dr. Tanner had determined to try and save a portion of the hand; how much of it could have been left with any chance of success? The first, second, and third metacarpal bones were so crushed, that it was completely out of the question to make an effort to save them; whilst the metacarpal bone of the ring finger, if saved, would have been completely useless, as the common extensor which supplies it was so torn that it would have all sloughed away. The only finger there was the slightest hope of saving was the little one, which would have been more in the patient's way than of any use to him.

We have seen the man a few times since he left the hospital, and he is in the enjoyment of perfect health.

SELECTIONS FROM BRITISH AND FOREIGN JOURNALS, &c.

Tubercle of the Brain.

Dr. Friedrich Stiebel, Physician to the Hospital for Diseases of Children in Frankfort, reports ten cases of this disease, and in nine the pathological appearances after death are reported. In one of the ten cases which presented symptoms identical with those of the cases which terminated fatally, recovery took place. Dr. Stiebel says, in arriving at the conclusion he has done in this case, he knows he is at issue with the highest authorities on the subject of the diseases of children.

Rilliet and Barthez, for example, say of tubercle of the brain:—"La maladie se termine toujours par la mort: du moins nous ne connaissons dans la science aucun example bien constaté de guérison."

In the case which Dr. Stiebel believes to have been one of tubercle of the brain, there were present the following symptoms: sudden vertigo, unconsciousness; transverse or cross convulsions; the left arm and right leg affected; at a more advanced period, subparalysis of the lower extremities, and headache. If the diagnosis of cerebral tubercle can be made during life, Dr. Stiebel is of opinion that this case was one. The fact of tubercle in other situations being susceptible of cure is undoubted, and it may be that absorption occurred in this instance. Fifteen months having elapsed since the establishment of perfect health there are grounds for believing in the permanence of the recovery.—*Journal für Kinderkrankheiten.*

Osteo-myelitis after Amputation.

Dr. Valette, one of the surgeons attached to the French army in the East, has lately written a memoir on this subject, an analysis of which was recently laid before the *Société de Chirurgie* by M. Majorlin. The observations which furnished the memoir were collected in the military hospital at Constantinople, during the winter of 1854, after the battles of Alma and Inkerman.

The general symptoms of this disease are very similar to those of purulent infection. The local evidences of it occurring in a stump after amputation are three principally:—

1. Protrusion of the medulla, in the form of greyish-coloured button-like tumour.
2. Separation of the periosteum from round the divided bone.
3. Protrusion of the bone between the lips of the wound.

M. Majorlin thinks this is the same disease described in 1831 by Reynaud, under the name of medullary inflammation of the long bones, and more recently noticed by Cruveilhier. Osteomyelitis may be either acute or chronic.

The acute form generally commences from the fifth to the tenth day, and is ushered in by rigors, fever, and sweating; soon delirium supervenes; the skin becomes icteroid, and there is insomnia.

At first there may be nausea, vomiting, or typhoid symptoms. Towards the close the symptoms, in their *ensemble*, closely resemble those of purulent absorption.

So rapid is the disease that death sometimes occurs three or four days after these symptoms first appear.

Pathology of the affection.—In a few cases no decidedly morbid changes were detected, but generally there were found those organic changes which are usually consecutive to pyæmia, as ecchymosis and abscess of the lungs or liver; pus in the muscles, veins, or joints. Locally two stages of the disease were met with; the first consisting in intense vascularity and increased density of the medulla; the second in purulent infiltration of the open spongy tissue, with small *depots* of pus in the medullary canal.

According to M. Valette the disease is generated by atmospheric influences. As to the nature of the affection, he admits the close resemblance that osteo-myelitis bears to purulent infection, and believes that it cannot exist without it. He regards it, however, as a more fatal disease, for whilst he has seen three cases of purulent infection after amputation to recover under the use of quinine, he has never known any to recover after osteo-myelitis has become developed.

When this affection is epidemic, M. Valette, thinks that resections and amputations, when the saw is employed, should be abandoned, and disarticulations substituted, whilst at the same time the wounded are scattered in tents. All local treatment he has found ineffectual, such as caustic, (*pâte de Vienne*) cautery, and cutting off the end of the bone. He therefore proposes the extreme measure of amputating again at the next joint, excepting the hip joint, as the chances after amputation here are so very small. Even when purulent infection coexists he would recomend this proceeding, "for," he says, "purulent infection is not necessarily fatal, whilst osteomyelitis has killed all who have ever been attacked by it."

The chronic form of the disease is characterized by the slowness with which the local affection is developed, it is therefore more insidious. —*Gazette des Hôpitaux.*

On some Singular Nervous Affections due to a slow Poisoning by Nicotine, inhaled during Smoking.

Siebert describes, in his Memoir "On the Diagnosis of Diseases of the Abdomen," a work which has just issued from the press, the pernicious effects of the use of the cigar. These effects depend on a slow poisoning by nicotine, and constitute serious affections of long duration, the causes and origin of which usually escape the notice of the practitioner, and determine the failure of the various modes of treatment employed.

Berzelius had already shown that cigars contained more nicotine than ordinary cut tobacco. In consequence of the mode of preparation which tobacco cut up for the pipe undergoes, the nicotine in it is already reduced to its minimum of activity. But this is not the case with the leaves destined to be converted into cigars; the latter, in fact, are not subjected to the same preliminary preparation. Accordingly, it is chiefly in consequence of the use of cigars that the affection to which we are directing attention is observed, and which consists in a very obstinate neurosis, slowly developed, under the influence of the continued ingestion of very minute quantities of nicotine. This neurosis takes the form of an irritation of the spine, and produces, according to the point of the spinal marrow principally affected, different eccentric phenomena, such as bronchial spasms, a feeling of suffocation, palpitation of the heart, gastrodynia and vomiting, mesenteric neuralgia, &c. As examples of this slow poisoning, we shall cite the following cases reported by Siebert:—

A very robust man, aged thirty, was from 1840 to 1845 liable to nervous attacks of the most varied kind, such as numbness of the forearms and hands, palpitations, hypogastric oppression, want of appetite, and even vomitings; spasms of the sphincter ani, and nocturnal seminal emissions, followed by great depression. The motor power of the lower extremities was from time to time disturbed; deambulation, as well as ascending a height, became uncertain; vertigo and double vision were superadded. These symptoms, at first attributed by Siebert to hyperemia of the spinal marrow, were combatted by cupping, leeching, and purgation, but they only got worse. Preparations of iron always gave relief, but without producing a complete cure. Siebert then insisted that his patient, who was in the habit of smoking a number of cigars of good quality, should abstain from them for at least four weeks. At the end of this time he felt himself quite another man. To complete his cure, he repaired to the chalybeate waters of Steben, which strengthened him much, and from which he returned completely restored. During the winter of 1845, he was tempted to smoke a cigar, when the symptoms above described immediately returned, and only yielded to the use of iron, continued for four weeks.

The second case was that of a man of cachectic and almost mummified aspect, who consulted Siebert for total loss of appetite. The only time at which his state was at all supportable was after smoking a very strong cigar. He was attacked regularly every afternoon with violent colicky pains, which lasted several hours. Purgatives were tried without success. For years he had tremors and weakness in the extremities, palpitations of the heart, and sometimes vomiting; for some months past he had, in addition, complained of a disagreeable sensation, like a blast, in the lower part of the spinal column, combined with intestinal pains recurring daily, commencing each time in the umbilical region, spreading through the entire abdomen, and becoming concentrated in the back; these pains were intolerable, rending, crushing, but ceased during the night. He was not subject to vomitings at other times, nor was there any derangement of the alvine evacuations. From the time that he gave up the use of cigars the symptoms entirely ceased; but not being able to deny himself the enjoyment of smoking beyond four weeks, he resumed the habit, and the pains returned.

Strong cigars at first excite the appetite and, after meals, favour stomachic digestion, which circumstance induces the true smoker to fly to his cigar immediately he has swallowed the last morsel. These individuals ought carefully to avoid any derangement of digestion. The appetite and the digestive powers soon diminish, enteric pains become developed, and at the end of a short time constitute true neuralgic paroxysms.—*From Chemist, January*, 1856.

BOOKS RECEIVED.

Dr. Bartlett on Consumption.
Chemist, January, 1856.
Glasgow Medical Journal, 1856.
Dr. Spence on Hernia.

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